PUBLIC DOLLARS, PRIVATE PREROGATIVES: LESSONS FROM MEDICARE FOR NATIONAL HEALTH REFORM

HEARING

BEFORE THE

SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES, AND TECHNOLOGY

OF THE

COMMITTEE ON SMALL BUSINESS HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

WASHINGTON, DC, MARCH 29, 1994

Printed for the use of the Committee on Small Business

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PUBLIC DOLLARS, PRIVATE PREROGATIVES: LESSONS FROM MEDICARE FOR NATIONAL HEALTH REFORM

TUESDAY, MARCH 29, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON REGULATION, BUSINESS
OPPORTUNITIES, AND TECHNOLOGY,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:37 a.m., in room 2359–A, Rayburn House Office Building, Hon. Ron Wyden (chairman of the subcommittee) presiding.

Chairman WYDEN. The Subcommittee on Regulation, Business Opportunities, and Technology will come to order.

Today the subcommittee continues its inquiry into the policy, practice, and procedure behind Medicare claims processing. At the subcommittee's request, the General Accounting Office has for several years been examining the inner workings of the little-known private Medicare bureaucracy.

Last summer, the General Accounting Office told the subcommittee that high school graduates without medical training, working at private insurance companies under contract with the Federal Government, process a new Medicare claim every 72 seconds, 8 hours a day. Not surprisingly, nearly two-thirds of the claims denied as a result of this half-baked process are overturned on appeal.

Given these alarming findings, the subcommittee asked the General Accounting Office to compare denial rates among the 34 private insurance carriers that administer Medicare to see if the Nation's senior citizens were in fact, being treated fairly.

The subject of this General Accounting Office report has direct consequences for small businesses and their employees and their retirees. Millions of small businesses lack retiree health benefits, and thus their workers are dependent solely on Medicare to meet their health insurance needs. In addition, there is considerable discussion in the Congress about using Medicare as a model for supplying health insurance for the uninsured, most of whom work in the Nation's small businesses.

Today's hearing is especially important because the General Accounting Office will disclose for the first time that there are radical disparities in the claims approval and denial ratings among the private insurance carriers that really run the Medicare Program. This new evidence raises serious doubts as to whether the Nation's

elderly are having their Medicare claims processed fairly. There is something very wrong when Medicare coverage for seniors is based more on where seniors live than on what seniors need.

Overall, the General Accounting Office found widespread and statistically significant discrepancies in the decisions made by six large Medicare contractors for four out of five of the health care items and services most often needed by older Americans. For three of five of these Medicare services stingiest contractor denied Medicare payment more than 10 times as often as the most generous carrier.

The General Accounting Office examined for the subcommittee the 71 most-used and costly Medicare items and services at large insurance carriers selected to represent diverse geographic areas. This review shows that Medicare, which most Americans believe to be a Federal insurance program under which seniors receive uniform benefits nationwide, is in fact, a crazy quilt of 34 separate and dramatically different programs run by private insurance companies. In addition, these private insurance companies seem to be virtually unscathed by Federal supervision and scrutiny.

For example, the General Accounting Office found that if you are an older woman whose physician prescribed that you get a diagnostic mammography to detect breast cancer, you are 180 times more likely to have Medicare deny payment for that mammography if you live in southern California than if you live in northern California.

Even an ambulance ride seems to be a source of boiling controversy at the Medicare Program. A one-way ambulance ride in Illinois is almost always paid for, but a claim for that same trip is 740 times more likely to be denied by the southern California Medicare carrier.

But before the Nation's senior citizens all go and move to Illinois, seniors should consider what happens if their doctor wants a chest X-ray to rule out lung cancer. In this case, seniors would be better off moving to South Carolina, because the Medicare contractor in Illinois is 500 times more likely to deny payment for your X-ray than is the South Carolina carrier.

These findings might be considered laughable if they didn't cause so much pain for our senior citizens on small incomes, who desperately need their basic health services covered. All too often doctors ask seniors to sign a document promising to pay for services that Medicare refuses to pay for. As a consequence, unpredictable Medicare reimbursement practices too often leave seniors vulnerable to huge out-of-pocket medical bills that they can ill afford. Seniors are fiercely independent and they believe in paying their bills even when Congress intended that Medicare should pay them.

In addition, the payment practices uncovered by the GAO are unfair to the Nation's physicians who wish to treat seniors under Medicare. Like their patients, physicians find themselves subject to the same arbitrary judgment calls of the private Medicare insurance monopolies that seem immune from marketplace accountability. Such practices may discourage physicians from providing certain services to the elderly.

Certainly some modest regional disparities in a national insurance program are understandable, and possibly justified because

doctors in one region sometimes disagree with those in another about the medical necessity of a given service. But the enormous differences in Medicare payments seem to stem from the fact that carriers have no uniform rules for taking into consideration local practice, and the result is chaotic coverage policy.

Look at California again, where the General Accounting Office found a 220 times higher denial rate for cardiac ultrasound services in southern California, compared with the other half of the State.

The General Accounting Office's report to the subcommittee today has profound implications for the national health reform debate in the Congress, as well as the future of the Medicare Program. For one thing, there is a certain striking resemblance between all major national health reform plans and the current Medicare Program: Both rely on a national standards benefits package and then turn over the program administration to private insurance companies. The General Accounting Office makes it clear that enactment of that national standard benefits package for all Americans will not be enough to ensure uniform coverage of health care for all our citizens.

For the future, both Medicare and any national health reform plan must define a clear set of payment and coverage standards and a way to ensure that Government and private payers comply with these standards. Holding private insurers accountable is one way to help achieve these goals, and this subcommittee intends to examine the idea of creating financial penalties for carriers that have too many claim denials overturned on appeal.

There is much more work to be done to get at the reason for the General Accounting Office's findings. But the General Accounting Office has pried open the lid on a Pandora's box of troubling questions of arbitrariness and inequity in the allocation of lifesaving medical therapies.

The chair wants to thank our witnesses, and especially, I would like to express the subcommittee's appreciation to the General Accounting Office for the exceptional service that they have performed in preparing this testimony. This testimony has been developed under the coordination of Dr. Eleanor Chelimsky with the assistance of Dr. Sushil K. Sharma and Dr. Richard Lipinski and the subcommittee, and in my view, the country owes them a debt for the excellent work that they have achieved in a very expeditious fashion.

We would also like to thank the Medicare Beneficiaries Defense Fund, a group that I have known since I was co-director of the Gray Panthers. They do excellent advocacy for the Nation's seniors and we are indebted to them as well.

We will call forward our first witness, Eleanor Chelimsky of the General Accounting Office. She is accompanied by Dr. Sushil Sharma and Dr. Richard Lipinski.

Again, let me express my thanks and appreciation to the General Accounting Office for their fine work.

[Chairman. Wyden's statement may be found in the appendix.]

Dr. Chelimsky, it is the practice of this subcommittee to swear all the witnesses who come before us. Do you have any objection to being sworn in?

Dr. CHELIMSKY. No, sir. None at all.

Chairman WYDEN. I think possibly Dr. Lipinski and Dr. Sharma may also be involved in answering questions; is that correct?

Dr. CHELIMSKY. Yes.

Chairman WYDEN. Do either of you have any objection to being sworn as a witness?

[Witnesses sworn.]

Chairman WYDEN. Again, Dr. Chelimsky, let me commend you for an excellent report. This is the second one that you have done for our subcommittee. We are very appreciative and look forward to your testimony, and please proceed in any way that you see appropriate.

TESTIMONY OF ELEANOR CHELIMSKY, ASSISTANT COMPTROLLER GENERAL, PROGRAM EVALUATION AND METHODOLOGY DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Dr. CHELIMSKY. Thank you, Mr. Chairman.

Good morning. It is a pleasure to be here today to tell you about our ongoing work that deals with the treatment of claims in the Medicare Program. I don't think that I need to present the two people who are here with me. You know them well.

I just want to report our findings today on denial rates based on six carriers' determinations of whether or not services received by beneficiaries are medically necessary. We are grateful to HCFA, the Health Care Financing Administration, for giving us the tapes that allowed us to conduct the analysis. In the near future, we will be able to report to you on the results of appeals made to reverse these denials.

As you know, Medicare today counts about 35 million beneficiaries and our six carriers cover about 7 million. Of these 7 million, we estimate that about 739,000 have their claims for at least one service denied for medical necessity. Of those 739,000, we estimate that at least 113,000, or 15 percent, got stuck with the tab for their medical care.

I have three findings to present here this morning. All are interrelated, representing different ways of looking at the same thing: The size of the variation and denial rates for medical necessity across six carriers.

Our first finding is that we examined the 71 most utilized and highest-cost services in the Medicare Program and found very large variations in denial rates across the carriers.

If you look at Table 1 in my statement on page 6, go down to about the middle of the page, you can see that service 92,014, for example, which is the HCFA code for an eye exam, varies from zero denials allowed per 1,000 allowed for South Carolina to 83.5 for the carrier in Wisconsin. So, it is a lot harder to find out if you have glaucoma or cataracts and being reimbursed for it in Wisconsin than it is in South Carolina.

Even a quick scan of the table makes clear how disparate these denial rates are. The only thing consistent about those numbers is their inconsistency. When we examined each service individually, we found that for 58 of the top 71—that is, about 82 percent, as you said earlier, 4 out of 5 the variation in the denial rates was statistically significant. As example, for chiropractic services, rates

of denial went from 18 per 1,000 allowed in Wisconsin to 174 in North Carolina.

Rates of denial for coronary angioplasty went from zero in northern California to 182 in southern California.

For diagnostic mammography, which you mentioned earlier, rates of denial were around zero for 5 carriers, but moved to 54 per 1,000 in southern California. Denial rates for heart catheterization were zero everywhere but in North Carolina, where they hit 189 per 1,000.

There is sizable inconsistency across the six carriers.

Our second finding shows the number of services screened by each carrier. As you can see in Figure 4, which is on page 13 of my statement, we found that only 25 of the 71 services are screened in South Carolina compared to 67 in southern California. We found also that the stringency of the screening for the same service varies across carriers.

So not only do denial rates vary, but the services are being differentially screened and screened at different levels of rigor.

Our third finding is that the overall denial rate—that is, for all services—by an individual carrier also varied significantly across carriers. Figure 5 shows that, looking at all 71 services, South Carolina denied only 1 service per 1,000 allowed, while southern California denied 23.

Now what can we make of this extraordinary diversity? At the heart of the matter we find, first, Medicare's policy which recognizes that because medical practices differ in different parts of the country, carriers cannot be expected to rule uniformly. Well, in practice what it has led to is each carrier doing its own thing in establishing individual medical policies for determining medical necessity, designing individual sets of criteria, and coming up with individual numbers of screens, and deciding individually on the stringency of their application. This is a far cry from not ruling uniformly.

Second, a number of other ideas have been advanced to explain the wide variations we have found. Hypotheses range from the possibility that different levels of fraud and abuse exist in different parts of the country to different levels of provider education in submitting Medicare claims. However, no data or other evidence have been presented to support these hypotheses empirically.

In trying to explain the wide variations we found in denial rates, I think two facts are important to remember. First, the findings presented today are new. Everyone thought there was variation in denial rates across carriers, but the size of that variation hadn't previously been calculated.

HCFA is only now beginning to conduct evaluations to examine the causes for the inconsistencies that we observed.

But why then is this inconsistency important? Well, there are at least three reasons. First, when medical necessity is inconsistently defined across carriers, this means that Medicare beneficiaries and providers are being denied reimbursement differentially, selectively on the unique basis of their place of residence.

Second, the size of the inconsistency we found is important because it shows to what degree inequities can occur as a result of

quite well-meant policies—in this case, local discretion about medical necessity.

Third, inconsistency is important because Medicare is not a local initiative. It is a national program under which beneficiaries should be treated equitably. Our findings show, however, that when carriers make individual determinations concerning what is and is not medically necessary, according to local medical practice, the services received by beneficiaries program-wide are not equitably distributed.

What then can be done? Well, carrier representatives told us that they believe that intercarrier variation would be considerably reduced if HCFA would establish a larger number of national medical policies that define very specific parameters for what is medically necessary. This seems to us a very reasonable assessment, but we also believe that HCFA needs to play a greater role in the oversight of carriers' claims reviews to ensure that treatment of Medicare patients across carriers is equitable.

Mr. Chairman, that concludes my remarks. We would be happy to answer any questions that you might have this morning.

[Dr. Chelimsky's statement may be found in the appendix.]

Chairman WYDEN. Dr. Chelimsky, thank you. You have summarized this very well. I must tell you that I just found your report stunning.

A year ago you told us about some of these problems that we found as a result of clerks processing claims every 72 seconds, 8 hours a day, and we thought then that there were going to be some problems in the way that these claims were being processed. But you have, I think, offered very, very significant findings, in particular, sending a message across this country that Americans, who thought that Medicare was a national program with uniform benefit standards, are instead getting something which is much along the lines of a hit-or-miss proposition that is determined by private insurance carriers.

So I want you to know that I think you have performed a great service to the country; in particular, your highlighting this matter of the inconsistency is extremely important.

On balance, you have got to say you want a low denial rate because a low denial rate means that the Nation's elderly are getting a fair shake and they and their providers are being reimbursed. At the same time, you want to make sure that people aren't ripping off the Medicare Program; you have got to also consider that when you look at these denial rates.

But what you have done is really highlight inconsistent treatment with respect to denial and approval. That is something that, as you say, has never been brought out.

Now, let me, if I might, begin our questioning by asking you to refresh the subcommittee's recollection as to the role of the way these private insurance companies develop their own medical policies to run the Medicare Part B Program.

Ms. CHELIMSKY. Well, sir, that has changed over time. I think some time ago the carriers developed these policies themselves; then they began getting some limited medical input from local groups. This, of course, applies to the data after the data that we have presented today.

Now, there are advisory groups that are beginning to be developed to provide local input to the carriers, but it is basically the carriers that develop their policy.

Did you want to add something to that?

Chairman WYDEN. Would you like to add something Dr. Sharma?

What is it about these locally developed policies that produce such wide variations in claims processing?

Dr. CHELIMSKY. I am not sure that there is anything particular about the fact that they are local. I think it is the fact that each one is developed individually without regard for what the others may have, which gives you this particular problem.

You have this in statistical policy all the time. When somebody develops his own data collection system and his own way of finding out what data are and another person does it very differently, then, of course, you are not going to be able to add them all together because they are apples and oranges; and I think that is what you have in this case.

Chairman WYDEN. It is really hard to imagine that these huge disparities in approval and denial of Medicare claims have somehow escaped the notice of the Health Care Financing Administration. They have analysts there, and you would think that they would be picking up on these radical disparities in the payments of claims.

Did your investigators come across any formal evaluations of variation in claims denial that were done by the Health Care Financing Administration?

Dr. CHELIMSKY. No, we were surprised also that they had not looked at this. But we did not find any evaluations.

They are beginning now, though, they told us, to take a look at what the causes of some of these disparities might be.

I was surprised myself at that.

Chairman WYDEN. Did you or any of your investigators ask the Health Care Financing Administration why they have not made any effort to try to look at these huge disparities in payment of Medicare claims?

Mr. SHARMA. We asked them this very specific question, and the answers were, first of all, yes, they were aware of the fact that there were some disparities in the denial rates. We were not given any specific answer as to why they had not looked, so far, but were told instead that they are looking at this. But they could not tell us when their results will be ready.

It is suspected that sometime this summer they will have some preliminary findings on this issue. But to be more specific, no specific reasons were given as to why they had not looked at it.

Chairman WYDEN. It seems, according to one comment I saw this morning, a comment in the Los Angeles Times, that HCFA kind of wants to wash its hands of it; that the Federal Government somehow through the Health Care Financing Administration says, it is not our doing. It is up to the Medicare contractors to analyze this data.

Is that reasonable, to push all of this off on the Medicare contractors?

Ms. CHELIMSKY. Well, I think you have to ask HCFA what their view is. It is hard for us to say what HCFA would like or would not like.

Chairman WYDEN. Let me read you then what they said there morning in the Los Angeles Times. Carol Walton, director, Medicare Operations for the Health Care Financing Administration said, "We expect the Medicare contractors to analyze the local data to see where there are problems with billing and to work with the local medical community to see if there are areas that need addressing."

It seems to me that is reasonable in terms of involving the local——

Dr. CHELIMSKY. But it doesn't solve the inconsistency problem. That is the problem. You need to have something at the Federal level. That is why I said in the oral just now that even if you get national medical policies, obviously you are never going to get rid of this need to have local medical input, so you are always going to have to have somebody harmonizing these policies across the 34 carriers.

Chairman WYDEN. You state it very well. I find that comment very alarming by the Health Care Financing Administration. It is one thing to see that we ought to have local input; that is something that we should support, the wide variety of reasons.

Your report has noted the possible differentials as they relate to fraud or local billing practices and the like. But for the Health Care Financing Administration to say, as they seem to have in the press, that they want to wash their hands of it, that it ought to be just done by these local private insurance companies seems to me to be a real breach of their responsibility; and I appreciate your answer on that.

Now, consumer organizations and physicians have argued for many years that the Medicare Part B Program is afflicted by these kinds of widespread discrepancies. Some of them, including Katy Samiljan, who will be here in a bit, have called for national medical policies that would promote greater equity for Medicare recipients and physicians alike.

What do you think of that suggestion?

Dr. CHELIMSKY. Well, we haven't finished our work yet, but at the present time that looks very reasonable to us, that we need more of those. Because even the carriers themselves say that, they feel that a lot of the disparity would be reduced. I am not sure it would ever be entirely eliminated, but certainly reduced if we had more national medical policies.

Chairman WYDEN. Let's look for a moment at the matter of chiropractic care, an area of significant importance to senior citizens. This is an area where the Health Care Financing Administration has, in fact, published national medical policy. But your study nevertheless showed that chiropractic services were plagued by the same radical variation in carriers' interpretation of the benefit. What does this say about even the work that the Health Care Financing Administration is doing now?

Dr. CHELIMSKY. I guess we would say that it doesn't go far enough. The parameters are not specific enough and it allows an awful lot of contrasting interpretation on the part of—I think we

have got a discussion of the differences in the statement about that.

I think you have to have very specific parameters.

Chairman WYDEN. What barriers would you see confronting the Federal Government if it was going to develop better and clearer national policies for the Medicare Program?

Dr. CHELIMSKY. Well, I think it certainly is necessary to have balance, as we have said, between the idea of local input and equity across the program, and that balance is always to be difficult to achieve.

I think one of the barriers is that we would expect too much of those national policies and think that we have got it made just because we have got them, because I think that there will always be variations, and somebody has to look over that and harmonize what is happening.

I think they may be costly. HCFA had told us that they thought that developing national medical policies would be costly. On the other hand, having 34 separate policies being developed doesn't seem to me to be very cost effective either. So, that is another issue.

I think a third thing would have to be done very carefully so that physicians across the country don't have the idea that anybody is trying to dictate medical practice. It could look like that. Any time you do something nationally, educators worry about that, judges worry about that, that policy is being dictated.

So I think that those are three barriers: Achieving balance, cost, and physician reaction.

Chairman WYDEN. Is the Health Care Financing Administration making progress with respect to developing these national medical policies? Are they increasing their library of these kinds of policies to guide the Medicare carriers?

Mr. SHARMA. What we have been told is that only recently they have made some attempt to compile all the different policies that these different carriers have. We do not know what specific plans they have beyond the collection of policies in terms of syntheses of those policies, identified variations, to find out what are the causes for those variations and what ought to be done.

Dr. CHELIMSKY. It is certainly a first step. If you are going to do something, you need to put them all together and see how different they are.

Chairman WYDEN. One of the things that I am concerned about as we try to sort through this is that we already have something of a blame going on. You all have sort of opened Pandora's box, and now we have got a situation where the carriers seem to say, it is HCFA's fault.

I note on page 19 of your testimony the carriers said that HCFA has to establish more national medical policies so that there are specific guidelines for what is medically necessary. At the same time, as I read you from this morning's news account, the Health Care Financing Administration seems to be blaming the carriers saying, well, we can't analyze all these claims.

I am concerned that the senior citizens and the physicians are going to get lost in the shuffle between all of this elbowing back and forth trying to impute blame. What is your reaction to that?

Dr. CHELIMSKY. My reaction is, welcome to the modern world. It just seems that everything I ever do at GAO inspires some sort of blame game that comes after it. I don't know what you do about it except take a look at what HCFA has said and what the carriers have said.

It seems to me that the carriers are being quite generous when they are saying that HCFA ought to do that. HCFA's statement that the carriers can do it alone doesn't make a lot of sense to me if we are talking about inconsistencies. If we are talking about something else, then of course that is quite reasonable, but not inconsistencies across the carriers.

Chairman WYDEN. You don't think there is any question that HCFA has got to be more aggressive in this area?

Dr. CHELIMSKY. I think they must be more aggressive; yes, we have said so. We haven't said so very strongly, because we haven't finished our study. But at the present time, that is certainly where we are.

Chairman WYDEN. Let's take your statement on page 19, "We believe that the Health Care Financing Administration needs to play a greater role in using such data"—talking about denial and approval data—"to oversee the carriers' claims review activities to better assure that beneficiaries and providers are equitably treated."

Based on your work, how could they do that? How could they play that greater role in a constructive kind of fashion?

Dr. CHELIMSKY. I think the first thing that I would see as a sign that things were developing in a monitoring way is that they would be examining these disparities, that they would be tracking them over time. I mean, that would be the first thing that I would expect to see.

You mentioned yourself that you don't know why they haven't done it. Neither do I. But that's why I think these denial rates are extremely useful.

Chairman WYDEN. Now, medical researchers believe that most of the underlying variation in medical practice is due to a relatively small number of physicians who do a lot of a given surgery or procedure. Under these circumstances, it would seem to make sense to focus carrier oversight on this key group of practitioners, rather than denying claims for all of the providers in an attempt to reduce overutilization of health care.

What do you hear from the Health Care Financing Administration about efforts to better target what they're doing in terms of reviewing medical necessity?

Dr. CHELIMSKY. I haven't seen the data that shows the numbers that are targeted; I haven't seen any data to support that, and so I wouldn't suggest that. But, Sushil, you may have seen——

Mr. SHARMA. They are going to be looking at this issue, this particular hypothesis, to see whether it is true or not. We don't believe that one or two people could explain that size of variation.

Chairman WYDEN. We would like to have you take a look at that, because certainly the medical research data generally shows that this matter of overutilization, while not one or two, certainly does seem to be clustered in a relatively small number of providers. In the private sector, what we find—and again, you don't get the feel-

ing that the Health Care Financing Administration seems to even be looking at what is going on in the private sector—but in the private sector, there is an effort as you try to review these claims that are approved or denied to target that relatively small cluster.

Are these screens that these private insurance companies use under Medicare applied to all the claims, or just those on some of the physicians? Maybe this is an appropriate question for you, Dr. Sharma.

Mr. SHARMA. First of all, those screens apply only to a limited set of services.

Chairman WYDEN. Why don't you explain what a screen is to the subcommittee, because even since my days with the Gray Panthers, the definition has kind of changed over the years, and explain what they are and how they work.

Mr. SHARMA. Screens are mechanisms to translate the medical policies into specific criteria that are then operationalized and put into a computer program language which, when the claim processors enter the information about the claim——

Chairman WYDEN. Let me just interrupt you for a second.

So these screens again are largely an area where the private insurance company can do its own thing as it relates to Medicare; isn't that correct?

Mr. SHARMA. That is correct. So, even though there are national policies, the specific criterias are generated by the carriers. They use these criteria on the computer screens to flag claims that are considered to be either medically unnecessary or for other reasons they should not be paid. Each time that claim has a question mark, there will be a flag that would appear on the screen and that would indicate why the claim should not be paid.

Chairman WYDEN. These screens are now being applied to all claims or just to those on some physicians?

Mr. SHARMA. For medical necessity, there are only limited number of services for which these screens are identified. But let me tell you, there are more than one way that, theoretically, can be looked at in terms of what to do with physicians who are the outliners.

One of them, of course, is the prepayment screens. But HCFA traditionally used the postpayment review methodology in which they go back and take a look at what is the extent of the reviews and they take a look at the claims by physicians and they compare if there is somebody who has submitted—let's say, for example 100 claims for 10 patients, and while most—for a given service; and while others are only submitting 50 claims for 10 beneficiaries, then they would identify that something is going on wrong with this person and would take an in-depth look at that person.

I don't believe that prepayment screens are effective ways to really target those specific apparent practices.

Chairman WYDEN. What would be a specific way, in your opinion, based on your research to, try to root out this relatively small number—or we believe a small number based on the research outside Medicare—that really seems to be fleecing the program and taking advantage?

Mr. SHARMA. We have not done any specific work on this area, but we do know that HCFA has—is planning to implement what

is known as "focused medical review." We have not looked at the specific methodology or specific plans that they have with regard to this methodology.

Chairman WYDEN. So, you are picking up from the Health Care Financing Administration that they are talking about in the future implementing something called "focused medical review" to try to target the providers that seem to be exploiting the program. Based on what you now know—and again, the reason why we have to ask you is because we have not found the Health Care Financing Administration exactly forthcoming in discussing these matters with the Congress—what is this focused medical review based on? What they have told you?

Mr. SHARMA. Again, they didn't tell us much about focused medical review, so what I have is sort of basic information that I would have about this methodology that I would not be able to generalize.

Chairman WYDEN. Based on what you know, does this concept seem to have some progress for rooting out the abuses?

Mr. SHARMA. It has promise if it is implemented correctly. I think what is important is, how do you really implement this process or this methodology? I have no idea of how HCFA plans to implement this method.

Chairman WYDEN. One of the reasons offered by the Health Care Financing Administration, Dr. Chelimsky, for this huge variation in Part B carrier claims decisions is the underlying disagreement of the Nation's doctors regarding effective treatment. But we had our staff look up the medical literature on variations in medical practice and found that these studies show, for example, "Bostonians use 4.5 hospital beds per thousand members of the population as compared with fewer than 3 beds per thousand for New Haven." Another example was, "A Bostonian is about twice as likely to undergo a particular surgery on the carotid artery in the neck as a New Havenite." For coronary artery bypass operations, the risk is reverse.

Another study of Medicare finance for this particular surgery found variations from 48 to 178 per 100,000 population; that is, the highest rate was 3.7 times higher than the lowest rate.

All of this is certainly of concern, but none of this evidence of variation in medical practice approaches this 180-fold variation you found—that is, mammography—or the 500-fold variation that you found for chest X-rays; or the 700 percent variation that you found in the area, I believe, it was of ambulance services.

So, again, what we find so distressing about this is that the variations you are picking up seem enormously larger than what is going on in the private sector. Isn't that the heart of why Congress ought to be concerned about this matter?

Dr. CHELIMSKY. I think that is exactly right. It seems to me that we all know that there is regional variation in medical practice. We know that's true. Until the doctors themselves decide that they ought to do things uniformly, which may never happen and probably shouldn't happen, we are going to have that variation. But that does not explain at all the size of the variation that we found. It is just too big.

So, say, that it is due to some small thing or another small thing, as opposed to the difference—the incongruence of the different

medical policies—seems to me it is like the doctors say that when you hear hoof beats, don't look for zebras, look for horses.

We know that there are medical policies here that are absolutely disparate. So, the issue of consistency, it seems to me, is not explained. The denial rates we found are much, much too inconsistent for the explanation to be regional variation.

Chairman WYDEN. Well, I think that your report has really altered the landscape of the national health reform debate. It seems to me that you have highlighted a central administrative concern that has got to be true for any national health reform program, just as it is with Medicare, and that is, that no matter where the money comes from, someone competent and accountable has got to review the claims and decide what is going to get paid for and what is going to be denied.

I am going to make sure that my colleagues understand the information that you have given us.

Medicare is a wonderful program. It has been a lifeline for millions and millions of seniors. But what your report has really shown is that not only must Congress protect and preserve this program that has been so important to seniors, but it had better take steps to improve the way the program is administered, and also use those lessons to apply better administrative principles to any national health reform package that is enacted.

Dr. CHELIMSKY. I couldn't agree more, Mr. Chairman.

Chairman WYDEN. You have performed a great service. We will look forward to working with you and continuing our inquiry and we will excuse you at this time.

Dr. CHELIMSKY. Thank you, Mr. Chairman.

Chairman WYDEN. Our next witness—in fact, let me see if the staff for the minority—we want to express our appreciation to the Ranking Minority Member, Larry Combest of Texas. This hearing was originally scheduled for Thursday last, and it was awfully hectic as Congress moved to the recess, and Congressman Combest has not been able to be here because of a schedule that he has with his constituents. But we want to express his appreciation and inform the minority we will hold the record open for the statements and questions of any Member.

Chairman WYDEN. Let us call now Ms. Katy Samiljan with the Medicare Beneficiaries Defense Fund.

Ms. Samiljan, we welcome you. Good to have you with us again. Your program has done a tremendous amount of good work for the Nation's senior citizens, and we appreciate your participation.

We do make it a practice in this subcommittee of swearing all witnesses who come before the subcommittee. Do you have any objection to be sworn as a witness?

Ms. SAMILJAN. No, I do not.

[Witness sworn.]

Chairman WYDEN. Ms. Samiljan, we will make your prepared remarks a part of the record. Please proceed in any way you think is appropriate.

TESTIMONY OF KATY SAMILJAN, HOTLINE DIRECTOR, MEDICARE BENEFICIARIES DEFENSE FUND

Ms. SAMILJAN. Thank you.

I would like to thank you and the subcommittee for the opportunity to address the Committee on Small Business' Subcommittee on Regulation, Business Opportunities and Technology. My name is Katy Samiljan, and I am the director of the Hotline Program at Medicare Beneficiaries Defense Fund.

As you know—you have met us before—Medicare Beneficiaries Defense Fund is a national not-for-profit organization that works to assure equal access to quality health care for seniors and people with disabilities and Medicare. MBDF identifies the failings and limitations on the Medicare Program, recommends systemic changes to correct them, educates the public about Medicare issues, empowers beneficiaries to help themselves, and, where necessary, we take corrective action on their behalf.

MBDF, our acronym for Medicare Beneficiaries Defense Fund, provides Medicare beneficiaries with direct assistance through the telephone hotline program which I direct. In 1993 alone, MBDF received more than 8,000 calls concerning Medicare and related health insurance problems on our telephone hotline.

The General Accounting Office findings support MBDF's experience with the Medicare Program. I want to present the human side of the story quantified by the GAO report.

Arbitrary and irrational denials by carriers do tremendous harm to Medicare patients. These arbitrary denials are especially troubling because they affect seniors and people with disabilities in poor health and living on small fixed incomes, often near or at the poverty line. Medicare carrier practices have left too many sick patients without care, without coverage and without meaningful recourse.

Arbitrary claim denials are the single most intractable problem facing seniors and people with disabilities on Medicare. These claim denials affect at least 15 percent of our clients. Local Medicare carriers use, as Dr. Chelimsky explained, these computer-driven tests called utilization screens which determine which treatments a Medicare carrier will cover and which they will not.

In some cases a Medicare carrier will provide coverage and other times deny it to the same patient for the same service performed by the same provider. In others, a Medicare carrier will cover some beneficiaries and deny coverage to others for the same service. Or one carrier will deny coverage for a service, while a different carrier will provide it. In cases like these, the Medicare carrier maintains that the care was not medically necessary as a pretext for denial.

We have no doubt Medicare carriers throughout the country are arbitrarily and improperly denying claims for several hundred thousand Medicare beneficiaries each year. Unlike many Medicare issues, however, we believe that this problem can be solved easily and completely. Congress must require HCFA to exercise greater oversight for carrier policies and practices concerning claims review.

My testimony today will address four main points: The pernicious effect carrier coverage discrepancies have on Medicare patients, why these coverage discrepancies occur, how to correct them and the impact that the subject of these hearings should have on national health care reform, particularly because several proposals

call for the expansion of Medicare to include Americans who do not currently have medical insurance.

When Medicare carriers improperly deny coverage and reimbursement, beneficiaries are ultimately the victims. Scores of our clients are threatened and harassed by collection agencies seeking payments for services that Medicare carriers should have reimbursed. Other clients have reported that the carrier's mistakes have made it difficult for them to receive further treatment from their doctors. As a result of these improper denials, many patients end up paying for their care privately or forgoing care altogether because they cannot afford its cost.

Tragically, most beneficiaries wrongly believe that Medicare does not cover their services, and they never learn that the denials could be the result of the carrier's arbitrary utilization screening process. Consider these examples:

One of our clients, whom I will call Mr. J, received an ultrasonic exam of the prostate because his physician suspected prostate cancer. Pennsylvania Blue Cross and Blue Shield, the carrier for his area, denied payment. The explanation of Medicare benefits form Mr. J received simply states: The information we have in your case does not support the need for this service. Mr. J never received any clarifying information and, when Medicare did not pay, the doctor sent his bill to a collection agency.

Another client, Mr. T, was forced to pay $1,050 up front to his doctor for an MRI. Empire Blue Cross and Blue Shield reimbursed him $202.80 for a CAT scan. The explanation of Medicare benefits form does not even indicate that the carrier rejected the MRI claim and paid it as a CAT scan. Mr. T has spent the last year fighting Medicare for higher reimbursement.

Yet another client, Mr. G, received neurologic services for a problem following surgery. The Medicare carrier denied coverage for all of his neurologic services, totaling $1,635, stating that, "Medicare does not pay for these charges because the cost of care before and after surgery is part of the approved amount for the surgery." In this case, however, the neurologic care was completely unrelated to Mr. G's surgical care and should have been covered separately.

Mr. G has been challenging Medicare's denial for more than 2 years. He is severely ill and probably will not live long enough to collect his due Medicare benefits.

In each of these examples, MBDF's clients were denied coverage because the carrier arbitrarily and improperly determined that the procedure was not medically necessary, despite medical consensus and common sense that suggests otherwise. Moreover, in the last several months, MBDF has seen wrongful denials for many other procedures such as for anesthesiologists who are standing by in case of emergency, for injections in conjunction with CAT scans of the pancreas, for biannual Pap smears with women with a history of cervical cancer, for physical therapy visits, for MRI's, for chiropractic visits. All of these services should have been covered by Medicare.

These denials devastate our clients financially and emotionally. Our clients alone are denied hundreds of thousands of dollars in Medicare benefits that they cannot afford to lose. Arbitrary denials

also unfairly jeopardize the health care of many beneficiaries who live on small fixed incomes.

Some providers understand the flexibility of the Medicare Program and can ensure that Medicare covers the care that their patients receive. But many providers do not understand carrier practices or do not want to bear the burden of challenging Medicare. They may not be willing to deliver services if they suspect that Medicare will improperly deny coverage. Instead, they often shift the burden of securing Medicare coverage onto their patients by requiring their patients to sign agreements to pay privately for their care. Patients who cannot afford to pay privately do not get treated.

The best evidence that carriers are improperly denying coverage to elderly and disabled patients is the fact that 60 percent of those beneficiaries who currently appeal Medicare denials secure coverage for their care. MBDF's experience shows us that, with proper documentation, beneficiaries can virtually always increase coverage for their care on appeal.

Congress should view the reversal data as evidence that the carriers are acting rashly to deny coverage and that HCFA has not acted to ensure that carrier administration of Medicare claims comports with law. Congress must recognize that most seniors and people with disabilities on Medicare do not understand their coverage rights or their right to challenge Medicare denials. They believe that fighting the bureaucracy is futile and resign themselves instead to despair and frustration.

I would like to take a moment and explain why—three explanations that we see for arbitrary Medicare denials and for the substantial variations that the GAO has found in denial rates across carriers.

The first reason we see is that carrier medical staff have enormous discretion in establishing Medicare coverage policies. They set medical necessity standards for many procedures by establishing utilization screens to determine which treatments they will reimburse and which they will not. These screens may limit the number of times and under which conditions they will cover a particular service. Their virtual unilateral control over medical policies results in the wide coverage discrepancies so injurious to Medicare patients.

Second, carrier staff generally lack the formal medical training and the time to make a fair determination of the medical necessity of a service. They are underskilled, undertrained, and yet they are expected to process hundreds of claims a day. Even if they have the skills and the time, carrier staff do not typically have any case-specific documentation to review and no tools other than the carrier screens to deny the claim.

Third, HCFA fails to exercise adequate oversight over carrier coverage practices and policies. HCFA has not provided needed funding for carriers to hire and train claims processing staff who can appropriately review claims for medical necessity.

Now, how do we fix the discrepancies? With congressional support, the problem of widely varying carrier determinations can be addressed.

First, HCFA, not Medicare carriers, should be required to set most, if not all, utilization screens.

Second, to the extent that HCFA does permit carriers to establish screens, HCFA must set strict guidelines for their content. Carrier-determined screens should be permitted only in exceptional circumstances for temporary periods where carriers detect patterns of abuse that HCFA has not yet addressed through screens. HCFA also must ensure that these utilization screens leave no room for arbitrary and irrational denials.

Third, HCFA must ensure that carrier staff have the time and skills needed to review claims for medical necessity.

Fourth, HCFA should require that in cases where claims are denied as a result of the application of utilization screens the explanation of Medicare benefits statement informs beneficiaries that additional medical justification is needed to secure coverage.

Recent proposals have called for the expansion of Medicare to include Americans who do not currently have health insurance. Before Congress can use Medicare as a model for health care reform, however, it should recognize that serious flaws permeate the Medicare Program that must be corrected. We believe these flaws can be addressed as follows:

First, beneficiaries should be removed from the reimbursement process. Beneficiaries whose claims are denied because they have exceeded utilization thresholds are forced into bureaucratic battles with Medicare, which they cannot fight. Many are forced to forgo much-needed coverage. While MBDF applauds HCFA's efforts to remove beneficiaries from the reimbursement process, we believe that these efforts must be increased before they will be effective.

Second, determinations of medical necessity should be based on national standards developed by HCFA. HCFA should also develop any utilization screens carriers have no choice but to use and to ensure that the screens are applied properly.

Third, carriers should have incentives to process claims correctly and penalties if they do not. For example, they should be required to pay interest and claims they erroneously deny.

Fourth, Medicare carrier staff who assist beneficiaries must have a solid mastery of the Medicare Program or the ability to find out answers quickly and accurately.

Fifth, consumer information and education must improve in content and increase in volume before Medicare parents can truly understand their rights. MBDF applauds the congressional appropriation of $10 million for health insurance counseling services both this year and last. The $40,000 contract we hold through the New York State Office for the Aging helps us serve more than 800 callers a month. Unfortunately, $10 million a year is not nearly enough to serve all the beneficiaries requiring assistance.

Finally, Medicare must be expanded to include the full range of health care services, preventive services, prescription drugs and long-term care.

The best health care system we can offer our citizens is one that provides necessary care and coverage for that care in a fair and equitable manner. Congress must work from this premise as it scrutinizes the Medicare Program and contemplates the future of health care in this country. Seniors and people with disabilities on Medi-

care suffer considerably from arbitrary claim denials. As a group, they are shortchanged millions of dollars. Individually, they are suffering physically, financially and emotionally, and they are forgoing necessary treatment.

Since its creation, Medicare has achieved great successes. However, much work needs to be done before America can proudly say that Medicare provides the equitable health care coverage that patients so desperately need. As Congress grapples with health care reform, it should proceed cautiously if it believes that Medicare offers a road map for the future course of health care in this country.

That will conclude my remarks. I would be happy to answer questions.

Chairman WYDEN. Thank you, and thank you for an excellent presentation.

[Ms. Samiljan's statement may be found in the appendix.]

Chairman WYDEN. How many cases do you all handle in a typical year?

Ms. SAMILJAN. In a typical year, let's see, we get about 800 calls a month. We have—last year, the beginning of the year, we were getting cases that were problematic that needed to be followed up on, 150 a month. Since then it has doubled—it has more than doubled. We are up to 355 cases a month.

Chairman WYDEN. So, if anything, the number of cases of confusion and uncertainty has increased rather than——

Ms. SAMILJAN. Absolutely.

Chairman WYDEN. That is my sense as well.

I get a call probably every week or 10 days from someone who might be in their 30's and 40's who is a lawyer, an accountant, and it really goes something like this:

Person would get on the phone, say, Ron, I remember what you were doing before you went to Congress. You worked with the Gray Panthers. I have been trying to sort through my mom's Medicare bills or my father's Medicare bills, and I can't do it. What do you think I ought to do?

Ms. SAMILJAN. Absolutely. Medicare is—we get hundreds of calls like that—I mean hundreds of calls every month from people who want to know what does Medicare cover. Medicare, as it stands now, is a total mystery to people. It is chaotic. They don't know their rights, and they are afraid to find out. They are afraid that they will somehow be penalized if they seek appeals or if they ask for a review. They don't understand why claims have been denied nor do they know how to fix problem.

Chairman WYDEN. What does it say about the Medicare Program, which is, again, the only Federal national program, that lawyers and accountants, people who are skilled in handling documents and complex forms, what does it say when they can't sort it out and call up someone like yourself or myself?

Ms. SAMILJAN. We can't sort it out sometimes. We don't have the answers to the doctors' or lawyers' questions either, all the time. I think about the Medicare Program—it says that we need to make these screens national.

I think one of the biggest problems, as I said before, is that Medicare is a mystery, and it doesn't have to be. We need consumer

education, we need to make these screens national, and we need to make them public information.

HCFA appears to believe that if we make these screens, these medical policies, information that is public, that doctors will somehow try to get around the system. But, frankly, right now if you are a doctor and you have been in practice for more than 2 years or even less than 2 years, you know what the carrier will accept and will not accept. That shouldn't make a difference. Medicare patients should be able to make informed choices.

Chairman WYDEN. It seems to me that giving out that information would give everybody more certainty.

Ms. SAMILJAN. Absolutely.

Chairman WYDEN. It would give the provider more certainty. It would give the senior citizen more certainty.

You mention this matter of physicians asking senior citizens to sign these agreements saying that they will pick up the bill if Medicare doesn't. Is that happening more often?

Ms. SAMILJAN. It is incredible, yes. Every day we see more and more and more sick people who are—either the doctor either refused to see them or refused to continue seeing them.

We had one client who came out of the hospital—he had had a stroke. He went into physical therapy. He was in physical therapy for approximately 6 weeks. At the end of those 6 weeks he still needed more therapy. I mean, he was learning to stand, to walk, to talk again.

The therapist turned around and, knowing that Medicare would probably start—that their local Medicare carrier would begin to deny claims, asked the man to sign a waiver, to sign an agreement saying that he understood that Medicare might not cover this. Regardless of whether or not the waiver, that agreement, was legal, the fact was that when he didn't sign it he didn't get any more care and he since died.

Chairman WYDEN. I gather that you feel that if there were these screens—and the screens I guess are another way for describing a national policy—this would give some predictability to doctors. It would give some predictability to seniors and might end up reducing the number of times physicians put these agreements in front of sick senior citizens saying, sign it; you have got to pay the bill if something goes wrong.

Ms. SAMILJAN. Yes. Especially if seniors have access to that information, if the staff is better, Medicare staff is better trained.

Right now you call Medicare and you simply can't get a straight answer out of Medicare staff.

Chairman WYDEN. We are going to—that was one of the things that I was thinking about when I mentioned that HCFA needs to do a better job in terms of working with advocacy groups, with the carriers, and pick up on some of your suggestions. Because if there is one thing national health reform ought to stand for, it ought to stand for empowering the public, making sure the people have more information so they can make better and more informed choices.

Ms. SAMILJAN. I couldn't agree with you more.

Chairman WYDEN. Maybe you are being too logical for the Federal Government. Your idea makes a lot of sense to me.

Let me ask you about some of the case histories, particularly this one involving the gentleman that Medicare Beneficiaries Defense Fund calls Mr. G. Now, Mr. G, I gather, is somebody that you all have been working with for a long time, you have been fighting his claims denial for 2 years and you feel he may pass away before Medicare ends up paying his bills. So, I guess a relative or spouse or somebody is going to have to pick it up.

Ms. SAMILJAN. I will say his wife don't usually speak to Mr. G. We speak to his wife. His wife is also ill. It is incredibly difficult for these people.

Chairman WYDEN. Tell us a little bit more about that case. I would like to know a little bit more about it.

Ms. SAMILJAN. Mr. G was admitted into the hospital for this particular group of claims that we have on appeal. He was admitted into the hospital for multiple gastrointestinal problems. I think the list I saw that documented approximately seven different medical problems.

Separate and apart from his stomach problems, from his intestinal problems, Mr. G had severe neurologic problems and had been seeing a neurologist. So, when he went into the hospital. He continued to see the neurologist on a more regular basis because she was afraid that his hospital stay, that his problems he was having there would make it necessary for him to see her more often.

But what happened was, when the doctor submitted these claims to Medicare, Medicare saw that there were more than the usual number of claims. They didn't request additional information. They just—the computers kicked out the rest of the claims. So, as a result, the patients were left holding the bag. They were left holding a bill for $1,200.

Chairman WYDEN. So that is what they are stuck with now?

Ms. SAMILJAN. Yes, that is what we are appealing now.

Chairman WYDEN. How would they pay it?

Ms. SAMILJAN. Well, good question.

Chairman WYDEN. Is this in New York?

Ms. SAMILJAN. This is in New York.

Chairman WYDEN. Does New York have one of these laws where they can put a lien on somebody's property or something?

Ms. SAMILJAN. That would be under Medicaid.

No, New York—well, the Federal laws which do limit how much a doctor can charge. There are seven States which have laws which further limit how much doctors can charge. So, federally, the law says that you cannot charge a Medicare patient more than 15 percent above what Medicare approves. So, if your bill is $100, you can't charge the patient more than $115.

Well, that is a lovely law, but the fact is it doesn't work. Patients don't know their rights. All they know is that if they don't pay the bill, invariably, as a matter of course, doctors send their bills to collection agencies when they are not paid, and they are harassed.

Chairman WYDEN. Probably a lot of seniors, with seniors just being so independent, possibly not knowing about your program, they end up just paying it right at the outset.

Ms. SAMILJAN. Absolutely. Or people will find out about us a year and a half later and come to us for help.

Chairman WYDEN. Now, are these kinds of protracted appeals common, the kind of situation that you described with Mr. G?

Ms. SAMILJAN. Yes.

Chairman WYDEN. There aren't any deadlines and time requirements in Medicare to prevent these endless appeals from outlasting the seniors?

Ms. SAMILJAN. Well, there are. They have to—if Medicare needs more time I believe they have to tell you that they need more time. It takes a long time to get a hearing date. I don't mean to be negative about the appeals process. Yes, it is burdensome, it is cumbersome, and many, many people are very frightened. They don't want to go through it. But it is the best we have got.

For some people it does work. For many, it doesn't. We had one client who knew that he had the right to a fair hearing and refused, even though we told him he didn't have to go and we would represent him, because he was afraid that he would get into trouble.

Chairman WYDEN. Let me ask you about another area that is of growing concern to me. We are talking about how difficult it is to sort through this Medicare mess if you are a lawyer or an accountant, somebody who is well-informed. In fact, I remember one group of seniors called it a Medicare migraine, described how they try to wade through all this confusion.

I would think that the kind of problems that you and Ms. Chelimsky told us about earlier would serve as even more of a barrier to low-income seniors or those for whom English is a second language. Do you have any reason to believe that the Medicare claims adjudication and appeals process has been discriminatory in terms of racial or ethnic minorities?

Ms. SAMILJAN. That the appeals process has been discriminatory?

Chairman WYDEN. Yes.

Ms. SAMILJAN. I can't say that I do at this point. But, however, we don't have many clients. We are not reaching—we are seeing that the appeals process is not necessarily—not enough clients come to us from minority and low-income groups.

Chairman WYDEN. How about low income?

Ms. SAMILJAN. We meet as many as we can.

Chairman WYDEN. How about low-income people? What is their prospect to being able to navigate through all of this?

Ms. SAMILJAN. Not very good if they don't find somebody to help them.

Chairman WYDEN. Pretty much nonexistent, isn't it?

Ms. SAMILJAN. Right.

Chairman WYDEN. Now, yesterday's *New York Times* carried a front-page story about people who have sued insurance companies to get coverage of treatment that those insurers regard as experimental. Now, this is an important area, one I think the Congress is going to be involved in. Certainly Government can do more to help insurers understand when a given medical treatment is effective and when it isn't.

But since these questions seem seldom cut and dried, it seems that people with resources are going to more and more go out and try to hire lawyers to represent them, and the lawyers will be in

a position to try to get them the best deal they can from private insurance company in terms of coverage.

Obviously, one, again, wants to avoid that kind of two-tiered health system. We want to make sure, as part of health reform, that everybody gets a fair shake in America, and it is not a question of getting covered just on the basis of the amount of money you have in your pocket. What recommendations would you have for Medicare to try to make sure that there is an administrative process for appealing a denied claim that is equitable and not just equitable for people who are well to do or know where to easily look for assistance?

Ms. SAMILJAN. Well, first of all, we would recommend that, as I mentioned in my oral testimony, that you take the Medicare patient out of the loop, that they are not—that the burden, that doctors don't put the burden on the patient.

Why should a patient have to hire an attorney or look for free legal services? There is no reason for that. The burden should be on the doctor. Who knows better what and why his patient needed or her patient needed and why they got that care than the doctor? The doctor should absolutely be the one to argue in the Medicare patient's favor. I think that is really the most important thing, is that the burden should not be on the patient who is sick and tired and scared.

Chairman WYDEN. You said at one point there weren't sufficient funds in the Medicare Program to run a timely and fair appeals process. Why don't you amplify on that?

Ms. SAMILJAN. Where are you looking?

Chairman WYDEN. I thought that was one of your comments, that you thought Medicare had not allocated sufficient funds.

Ms. SAMILJAN. Oh, there absolutely should be more funds for—not for the appeals process, I don't think, but for general counseling, for people to know about consumer information. I don't necessarily see that—the review process should not be difficult. With the help of a doctor, it is not a hard process to navigate. I think the biggest problem is fear.

So the funding we need needs to be in education. We have got to educate the patients and educate the doctors.

Chairman WYDEN. So possibly with more resources or kind of redirecting of priorities to counseling and making sure people knew their rights and these clearer screens, you might be able to avoid some of the more costly processes involving appeals?

Ms. SAMILJAN. Absolutely. Because if the claims process is more efficient we are going to have fewer hearings. While there will always be, to some extent, discrepancies, we can make a preemptive strike and cut a lot of those discrepancies out of the system. These arbitrary denials don't need half as many as we have got.

Chairman WYDEN. Now, I have also been concerned that thousands of Medicare enrollees may be appealing and reappealing the same issue that arises from a flawed local medical policy developed by 1 of the 34 Medicare carriers. What can you tell the subcommittee about the carrier's willingness to identify a flawed medical necessity guideline and then go out and correct it in one of their service areas?

Ms. SAMILJAN. Well, I am not sure that carriers move very quickly or efficiently or that they really do anything. They certainly don't have to answer to anybody for their medical policy.

I know, for example, we had possibly as many as 10 clients who were being denied for one service related to anesthesia in upstate New York, and everywhere else in the country, every other Medicare carrier, insurance company, was paying for the same service. Each time we had to take the claim through the appeals system until we got to an administrative law judge. They might have started to correct that now, but that has been 3 or 4 years.

Chairman WYDEN. I think that just hammers home why we need these kind of national standards, these screens that you are talking about. Because if you have a flawed medical necessity guideline and seniors and physicians don't end up being treated fairly, what you will have is people appealing and reappealing again and again and tremendous drain on resources while seniors don't get care and providers are——

Ms. SAMILJAN. Absolutely. Not only do we need these national policies, but we have to make sure that HCFA oversees that those policies are implemented correctly. HCFA can't make the national policy and then let the carriers run with it. There has to be constant oversight that these policies are put into use effectively.

Chairman WYDEN. Have you been able to see the national medical policies generated by the Health Care Financing Administration so that you could compare them with the local medical policies that are generated by the private carriers?

Ms. SAMILJAN. We are constantly on the phone with HCFA, finding out what investigating various aspects of Medicare coverage according to the Health Care Financing Administration. There are a million different—there are so many, I couldn't possibly explain them. But we see so many different things, so many different areas of Medicare where we know, where HCFA says, oh, yes, this is covered, and the Medicare carrier turns around and says, sorry, we don't think it is, or this wasn't necessary in your case.

So how do you feel if you are an 85-year-old man calls us, calls Medicare Beneficiaries Defense Fund, says, is this covered? We call HCFA, find out that it is. Two months later the same man calls us back holding a Medicare statement from his local carrier saying, I am sorry, your $5,000 operation was denied.

We see things like that every single day.

Chairman WYDEN. When the Medicare carrier says it is covered and the private carrier says it is not, then you sort of have gridlock, and the private carrier gets to make the initial determination, and you start this endless system of——

Ms. SAMILJAN. I am sorry. By private carrier do you mean the local carriers?

Chairman WYDEN. Yes. In the example you gave, you said you are on the phone. Medicare Program says it ought to be covered. The private carrier says it is not covered. You, in effect, have this gridlock, and that is what starts this appeals process that may end up with senior dying before it gets sorted out.

Ms. SAMILJAN. I think gridlock is the perfect word for it. The system doesn't move forward.

Chairman WYDEN. What about——

Ms. SAMILJAN. Actually, Mr. Wyden, I would like to suggest sometime that you call a Medicare carrier in your area and ask them if they cover something. Call them back 5 minutes later and make a third call the next day. I don't think you will like the results you get.

Chairman WYDEN. I have done that over the years, and you are right. It is a never-never land.

Ms. SAMILJAN. It hasn't improved any.

Chairman WYDEN. You get a wide variety of responses.

What about the willingness of the Health Care Financing Administration to correct one of these flawed policies in response to losing appeals? When they are losing appeals, does this agency then move to finally get it turned around quickly?

Ms. SAMILJAN. Not to our knowledge, no.

Chairman WYDEN. So we can have a situation like with Mr. G, you have got this kind of gridlock situation. It gets appealed and appealed and appealed. Based on what you have seen, even when the Health Care Financing Administration loses a big chunk of appeals, a lot of them, enough to show that there is a pattern, even then you don't seem to see that the Federal Government, the Health Care Financing Administration, moves to correct the flawed policy?

Ms. SAMILJAN. Right. The Health Care Financing Administration takes a totally hands-off approach to carrier policies. They don't seem to make any move to correct the situation. When they see that the policy appears to be severely flawed, it takes a long time to convince them to change anything. They simply aren't responsive.

Chairman WYDEN. Now, you stated, and I quote here, patients who want to appeal a Medicare denial require medical justification from their doctors. Amplify a little bit on that statement. Are the doctors willing to provide the requested documentation? Do seniors pretty readily ask their doctors? If you would amplify a little bit on that.

Ms. SAMILJAN. If a claim is denied because of medical necessity, the local Medicare carrier will ask the doctor for certain information. Sometimes the Medicare carrier gets that information, additional information, about medical needs of the patient, sometimes they don't.

It is not very efficient because, if they don't, the claim is simply closed, and, in theory, the Medicare patient should not be liable for the cost of that care. In practice, the claim goes to a collection agency, and they are billed endlessly.

Your second question, I believe, was do patients readily ask doctors for that information. The answer is no. They have a very hard time. They are afraid that they are going to lose the services of their doctor. It is very hard, especially now it is so hard for people to find new doctors. So, if you lose the one have you got, how are you going to get another one?

Chairman WYDEN. I gather from your testimony that many of the appeals are won simply because documentation supporting the doctor's judgment is provided to a carrier by the patient or the doctor. That is the case?

Ms. SAMILJAN. That is the case, yes.

Chairman WYDEN. Does this mean that the carriers are making so-called medical necessity judgments with little medical information about the patient?

Ms. SAMILJAN. Little or none. You are a claims processing person. You have 400 claims to your left. You are looking at your computer. Your computer says this person, according to our screens, doesn't need this service. So, you punch a button, and the claim is denied.

None of these have little or no evidence most of the time.

Chairman WYDEN. If carriers have to decide whether a service is medically necessary but cannot routinely obtain the medical information needed to make this judgment, it seems likely there would be an awful lot of erroneously denied claims. Now, again, you could see why some errors might be acceptable, but if carriers minimize their mistakes by really targeting the providers who had a history of fraudulent or inappropriate prescribing, it seems to me that that would be a better way to really try to address this problem. Would you agree?

Ms. SAMILJAN. I would agree. We believe that with locals—if you need to have local medical policies because you are detecting—because the carrier is detecting patterns of fraud, then HCFA—what HCFA has to require is very strong objective evidence that these policies are in keeping with—well, first of all, strong evidence that there is a pattern of fraud in any one given area and evidence that these screens that they are using or these tests are in keeping with what patients' medical needs actually are. They should provide medical documentation for that, and they should provide as much evidence as possible as to why they need to have a particular medical policy and not in another area.

Chairman WYDEN. Now, some look at Medicare's 2 percent appeal rate and say this is evidence that the system works well. They say only 2 percent of the denied claims are appealed so everybody ought to just say things are hunky-dory and relax. Now it seems to me you have stated pretty unequivocally that you believe many more claims are not being appealed even though they ought to be appealed.

Ms. SAMILJAN. Correct.

Chairman WYDEN. Is that right?

Ms. SAMILJAN. Yes. Well, 2 million or 2 percent of how many millions of claims? We are talking about a lot of claims. We see a 60 percent reversal rate, at some point, in the hearings process. So, either on review if you are a Medicare patient, we see that Medicare patients are securing coverage either on review at the first hearing level or at the second hearing level. Sixty percent is an incredibly high amount.

Chairman WYDEN. So it is not fair, and it is not appropriate to say everything is just hunky-dory because only 2 percent of denied claims are appealed?

Ms. SAMILJAN. Everything is not hunky-dory.

Chairman WYDEN. I have to tell you, again dating back to the days when I was involved in the kind of work that you now do, that I think seniors get so frustrated about dealing with these claims that you can go and see an older person in their home—somebody takes out a shoe box full of claims, and they just say to you, I knew

I should have appealed on some of these, but it wasn't something I had the time or the energy to do. They just throw in the towel.

Ms. SAMILJAN. Sure. We almost always tell people to appeal. We say to them——

Chairman WYDEN. That is your counsel? When a claim is denied, you tell them——

Ms. SAMILJAN. We tell them to appeal, unless it is something unless the claim has been denied for a service which we know unequivocally that Medicare does not cover. For example, hearing aids are not covered. But, generally, we always tell clients to appeal.

Chairman WYDEN. Now, the Health Care Financing Administration seems to be saying that it is the carrier's job to work with the doctors to eliminate all this disparity and inequity. When you say the carriers really don't seem to have much inclination—folks do it, kind of a take it or leave it sort of attitude. What do you think of the Health Care Financing Administration's idea to just have the carriers go out and fix the problem?

Ms. SAMILJAN. The carriers can't go out and fix the problem.

We believe that the problem is a result of the fact that there is no oversight. Local medical policy is not an excuse—is not a legitimate excuse for these vastly different rates of discrepancy. We are talking not about an average person as defined in one area. We are talking about a sick person who needs a particular kind of care. They are not androids. They are human beings, specific cases.

Chairman WYDEN. One last question I had with implications for national health reform. It seems to me that what you have done and the work that you are doing makes a very strong case for making sure that any national health reform plan that is enacted by the Congress have a very strong appeals and grievance process.

Ms. SAMILJAN. Yes.

Chairman WYDEN. Congress is looking at a national standard benefits package as part of health reform. That, of course, is what most America thinks seniors are getting as well. You have painted the picture as well as the General Accounting Office that that is not the case. But, if anything, you have kind of reaffirmed in my mind how important it is that there be a strong appeals and grievance process, part of national health reform, or else we will have many more times the problems with people getting their rights in national health reform than we have seen with Medicare.

Ms. SAMILJAN. Absolutely. I absolutely agree with you. We have to have this appeals process in place in any policy, any national reform plan that anyone puts forth in Congress.

Chairman WYDEN. One last question, I guess. I said the other one was the last, but we will wrap it up with this.

What about this suggestion that you have, Medicare carriers might be required to pay interest on claims that they erroneously deny? How would that work? Lay it out, if you would, a little more specifically.

Ms. SAMILJAN. Well, for example, if a claim is denied because a utilization screen or a local medical policy was applied and the claim was incorrectly turned down without the carrier asking for more information, then that company that has been hired by the Federal Government to process Medicare claims should be forced to

pay some kind of penalty for making a beneficiary suffer, for making a Medicare patient suffer.

Chairman WYDEN. We are going to examine the idea. It is certainly one that deserves scrutiny.

You have been good to come. Anything further that you would like to add?

Ms. SAMILJAN. No, that is all. I thank you very much.

Chairman WYDEN. Let me thank you very much for coming. We are going to consult with you frequently. This has, in my view, been an extremely important hearing.

I think many of us suspected that there were some serious problems in administering Medicare. Certainly, the evidence we got last year about people processing claims every 72 seconds, 8 hours a day, raised real questions in our mind. Frankly, this new evidence suggests that we are going to just have to keep digging and work with people like yourself to try to straighten these problems out.

Medicare is supposed to be a national program. It is supposed to be a program that gives uniform benefits to the Nation's senior citizens, and it is supposed to be based on what seniors need rather than on where they live. So, you have given us very valuable testimony to help us push toward that important goal. We are going to consult with you and other advocates often.

We thank you very much for coming, and the subcommittee is adjourned.

[Whereupon, at 11:11 a.m., the subcommittee was adjourned, subject to the call of the chair.]

APPENDIX

OPENING STATEMENT OF REP. RON WYDEN
Chairman

PUBLIC HEARING OF THE
COMMITTEE ON SMALL BUSINESS
SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES AND TECHNOLOGY
THE U.S. HOUSE OF REPRESENTATIVES

PUBLIC DOLLARS, PRIVATE PREROGATIVES:
LESSONS FROM MEDICARE FOR NATIONAL HEALTH REFORM

March 29, 1994

Today, the Subcommittee on Regulation, Business Opportunities and Technology continues its inquiry into the policy, practice, and procedure behind Medicare claims processing. At the Subcommittee's request, the General Accounting Office has for several years been examining the inner workings of the little-known private Medicare bureaucracy.

Last Summer, GAO told the Subcommittee that high-school graduates without medical training, working at private insurance companies under contract with the Federal Government, process a new Medicare claim every 72 seconds, eight hours a day. Not surprisingly, nearly two-thirds of the claims denied as a result of this half-baked process are overturned on appeal.

Given these alarming findings, the Subcommittee asked GAO to compare denial rates among the 34 private insurance carriers that administer Medicare, to see if seniors were being treated fairly.

The subject of this GAO report has direct consequences for small businesses and their employees and retirees. Millions of small businesses lack retiree health benefits, and thus their workers are dependent solely on Medicare to meet their health insurance needs. In addition, there is considerable discussion in Congress about using Medicare as a model for supplying health insurance for the uninsured, most of whom work in small businesses.

Today's hearing is especially important because the General Accounting Office will disclose for the first time that there are radical disparities in the claims approval and denial rates among

the private insurance carriers that really run Medicare. This new evidence raises serious doubt as to whether the nation's elderly are having their Medicare claims processed fairly. There is something very wrong when Medicare coverage for seniors is based more on where seniors live than on their medical needs.

Overall, GAO found widespread and statistically significant discrepancies in the decisions made by 6 large Medicare contractors for 4 out of 5 of the health care items and services most often needed by older Americans. For 3 of 5 of these Medicare services, the stingiest contractor denied Medicare payment more than 10 times as often as the most generous carrier.

GAO examined for the Subcommittee the 71 most-used and costly Medicare items and services at large insurance carriers selected to represent diverse geographic areas. Their review shows that Medicare, which most Americans believe to be a Federal government insurance program under which seniors receive uniform benefits nationwide, is in fact a crazy quilt of 34 separate and dramatically different programs run by private insurance companies. In addition, these private insurance companies seem to be virtually unscathed by Federal supervision.

For example, GAO found that if you are an older woman whose physician prescribed that you get a diagnostic mammography to detect breast cancer, you are 180 times more likely to have Medicare deny payment for that mammography if you live in southern California than if you live in northern California.

Even an ambulance ride is a source of boiling controversy at Medicare. A one-way ambulance ride in Illinois is almost always paid for, but a claim for the same trip is 740 times more likely to be denied by the southern California Medicare carrier.

But before the nation's elderly move to Illinois, seniors should consider what happens if their doctor wants a chest x-ray to rule out lung cancer. In this case, seniors would be better off moving to South Carolina, because the Medicare contractor in Illinois is 500 times more likely to deny payment for your x-ray than the South Carolina carrier.

These findings might be laughable, if they didn't cause so much pain to seniors on small incomes, who desperately need basic health services covered. All too often, doctors ask seniors to sign a document promising to pay for services that Medicare refuses to pay for. As a consequence, unpredictable Medicare reimbursement practices too often leave seniors vulnerable to huge out of pocket medical bills they can ill afford. Seniors are fiercely independent and believe in paying their bills -- even when Congress intended that Medicare should pay them.

In addition, the payment practices uncovered by GAO are unfair to

doctors who wish to treat seniors under Medicare. Like their patients, physicians find themselves subject to the same arbitrary judgment calls of the private Medicare insurance monopolies that are immune from marketplace accountability. Such practices may discourage doctors from providing certain services to the elderly.

Some modest regional disparities in a national insurance program are understandable -- and possibly justified because doctors in one region sometimes disagree with those in another about the medical necessity of a given service. But the enormous differences in Medicare payments seem to stem from the fact that carriers have no uniform rules for taking into consideration local practice, and the result is chaotic coverage policy. Look at California again, where GAO found a 220 times higher denial rate for cardiac ultrasound services in southern California compared with the other half of the State.

GAO's report to the Subcommittee today has profound implications for the national health reform debate in Congress, as well as the future of the Medicare program. For one thing, there is a striking resemblance between all major national health reform plans, and the current Medicare program: both rely upon a statutory standard benefit package, and then turn over program administration to private insurance companies. GAO makes it clear that enactment of a national standard benefits package for all Americans will not be enough to ensure uniform coverage of health care for all Americans.

For the future, both Medicare and any national health reform plan must define a clear set of payment and coverage standards, and a way to ensure that government and private payers comply with these standards. Holding private insurers accountable is one way to help achieve these goals, and this Subcommittee intends to examine the idea of creating financial penalties for carriers that have too many claim denials overturned on appeal.

There is much more work to be done to get at the reason for GAO's findings. But GAO has pried open the lid on a Pandora's Box of troubling questions of inequity and arbitrariness in the allocation of lifesaving medical therapies.

The Chair wants to thank our witnesses, and express the Subcommittee's appreciation to the General Accounting Office for the exceptional service that they have performed in preparing this testimony expeditiously, and to the Medicare Beneficiaries' Defense Fund for the superb advocacy they provide to the nation's seniors.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Regulation, Business Opportunities, and Technology, Committee on Small Business, House of Representatives

For Release on Delivery
Expected at
9:30 a.m., EST
Tuesday
March 29, 1994

MEDICARE PART B

Inconsistent Denial Rates for Medical Necessity Across Six Carriers

Statement of Eleanor Chelimsky
Assistant Comptroller General
Program Evaluation and Methodology Division

GAO/T-PEMD-94-17

Mr. Chairman and Members of the Subcommittee:

It is a pleasure to be here to share with you the results of our ongoing work on the Medicare Part B claims processing system. As you requested, in our testimony today, we will present information on claims processed by six carriers that were denied for lack of medical necessity. To develop this information, we analyzed data provided to us by the Health Care Financing Administration (HCFA).

Before turning to the results of our work, let me briefly discuss the program and the process by which carriers determine medical necessity.

The Medicare program, authorized under title XVIII of the Social Security Act, is a nationwide entitlement program to provide health care benefits to persons 65 years of age or older, certain disabled beneficiaries, and most persons with end-stage renal disease. Once eligible, beneficiaries should not receive different benefits solely because their place of residence differs.

Since its inception, the program has grown considerably: The number of people with coverage increased from 19 million in 1967 to over 35 million. Currently, about 96 percent of those eligible for Medicare are enrolled. HCFA, within the Department

of Health and Human Services, administers the Medicare program and establishes the regulations and policies under which the program operates.

The Medicare program consists of two distinct insurance programs. Part A (Hospital Insurance Benefits for the Aged and Disabled) covers services furnished by hospitals, home health agencies, hospices, and skilled nursing facilities. Part B (Supplementary Medical Insurance for the Aged and Disabled) covers a wide range of medical services and supplies--including physician services, outpatient hospital services, and home health services not covered under Part A, as well as diagnostic laboratory tests, x rays, and the purchase or rental of durable medical equipment.

In accordance with title XVIII of the Social Security Act, as amended, HCFA contracts with 34 private insurance carriers to process and issue benefit payments on claims submitted under Part B coverage. Carriers are required to process claims in a timely, efficient, effective, and accurate manner. During fiscal year 1993, carriers processed about 576 million Part B claims submitted by about 780,000 physicians and 136,000 suppliers.

The Social Security Act mandates that carriers pay only for services that are covered, and reject the claim if they determine that the services were not medically necessary. In

fiscal year 1993, carriers denied 112 million Part B claims in whole or part (19 percent of all claims processed) for a total of $17 billion (which represented 18 percent of all billed charges, a figure unchanged from the previous year). The percentage distribution by reason of the dollar amount denied was as follows: duplicate claim (30 percent), service not covered (14 percent), claimant ineligible (8 percent), missing information (10 percent), rebundled (6 percent), filing limit exceeded (1 percent), Medicare secondary payer (6 percent), and other (16 percent). Services deemed not medically necessary constituted about 9 percent of the dollar amount denied by carriers.

With the exception of determination of medical necessity, the above reasons for denial are generally the result of routine administrative checks made during claims processing. Determining the medical necessity of a service, on the other hand, requires that carriers develop a medical policy that reflects local standards of medical practice and apply that policy in making determinations as to whether the billed service was performed in accordance with those standards. Carriers have been given broad latitude in this respect--that is, they have been given primary responsibility for defining the criteria that are used to assess the medical necessity of the services on a claim.

Concerning medical necessity, you asked us to assess whether there are differences among carriers with regard to the rates of

claims denied for this reason, and to describe the characteristics of the types of claims denied. In response to your request, we analyzed data on claims processed by six carriers to ascertain rates of claims denied specifically for medical necessity. This testimony presents our results. Our analytical methodology is given in Appendix I. A forthcoming report will examine these issues as they relate to the question of claims appeals.

FINDINGS

Our study addressed the issue of consistency in denial rates for the 71 most utilized and costly services across the six carriers we examined. We have three findings to report.

First, we found sizable differences among the carriers with respect to denial rates for the services screened for medical necessity.[1] The denial rates for the top 71 services are presented in table 1, and show notable variability across carriers. For instance, the first line shows the denial rates

[1]For the purpose of our analysis, we assumed that, if a carrier denied at least one service for reason of medical necessity, that carrier must have had a screen in place for that procedure code. It should be noted that, while a medical necessity denial constitutes evidence of the presence of a screen, the absence of denials for a particular procedure code, though strongly suggestive, does not preclude the possibility that the carrier may have had a screen in place. However, given that the top 71 services generally have high utilization rates, such screens, if they existed, must have been fairly inefficient.

for code 99213, billed for an office or outpatient visit (see Appendix II for a glossary of service codes), among the six carriers. For example, the Northern California carrier denied 0.4 services for every 1000 they allowed, while the Southern California carrier denied 3.7 services for every 1000 they allowed.

Table 1: Rates of Denial for Medical Necessity Per 1000 Services by Service Code and Carrier for 1992
(Top 71 Part B Service Codes, Ranked by Allowed Charges)

Code	N. CA	S. CA	NC	SC	IL	WI	*Sig.*
99213	0.4	3.7	0.3	0.0	3.7	9.7	*.01*
66984	0.2	10.8	5.5	0.0	1.1	0.0	*.01*
99232	0.9	13.7	0.4	1.7	11.9	17.1	*.01*
99214	0.2	4.4	0.3	0.3	3.8	8.2	*.01*
99231	0.3	12.4	0.3	2.2	13.4	21.5	*.01*
99212	0.6	7.9	0.5	0.0	5.5	18.4	*.01*
99233	0.8	22.9	0.3	2.1	9.1	20.4	*.01*
A0010	0.3	20.4	1.2	48.6	0.0	42.4	*.01*
93307	4.1	140.0	1.2	0.0	0.0	1.5	*.01*
88305	0.1	19.9	1.5	0.5	0.0	0.7	*.01*
99223	0.3	9.5	2.6	1.2	7.8	6.6	*.01*
99215	0.1	6.3	1.0	0.0	5.6	6.2	*.01*
99254	0.2	2.3	0.4	0.8	0.0	0.5	*.01*
66821	0.0	1.0	1.1	0.0	0.0	0.0	*N.S.*
A0220	0.4	10.8	0.0	47.2	0.0		*.01*
71020	0.4	12.4	0.9	0.2	103.2	0.9	*.01*
90844	0.2	9.9	1.0	0.0	0.0	0.7	*.01*
99222	0.6	11.3	1.5	3.1	9.8	2.5	*.01*
92014	0.1	2.8	1.0	0.0	2.5	83.5	*.01*
27447	0.0	2.9	0.0	0.0	0.0	0.0	*N.S.*
E1400	21.9	63.4	51.6	0.0	10.2	6.9	*.01*
99238	0.5	12.2	0.4	0.3	10.3	13.7	*.01*
93547	0.0	3.0	1.5	0.0	0.0	0.0	*N.S.*
80019	1.1	3.5	0.2	2.8	93.8	0.0	*.01*
99244	0.0	3.0	0.0	0.0	0.0	3.6	*.01*
A2000	77.1	72.2	173.9	116.5	142.8	18.3	*.01*
B4150		66.5		0.0	0.0		*.01*
77430	0.0	1.2	0.0	0.0	0.0	1.6	*N.S.*
B4035		66.8		0.0			*.01*
99255	0.4	2.6	0.0	0.0	0.0	0.0	*.01*
J9217	0.0	1.0	17.1	0.0	0.0	2.7	*.01*
90995	0.6	1.8	9.7	0.0	2.1	0.0	*.01*
93005	1.0	8.5	0.6	0.0	0.1	0.8	*.01*
92982	0.0	182.4	29.2	0.0	0.0	33.3	*.01*

Code	N. CA	S. CA	NC	SC	IL	WI	*Sig.*
99284	0.2	8.5	1.7	0.0	0.0	4.8	*.01*
99285	0.0	30.7	2.9	0.9	0.0	8.3	*.01*
45385	0.0	3.7	0.0	0.0	0.0	0.0	*N.S.*
92012	0.0	1.8	0.5	0.0	1.6	51.5	*.01*
45378	0.0	0.9	0.0	0.0	0.8	0.0	*N.S.*
99311	0.0	2.6	0.8	0.0	4.1	5.0	*.01*
71010	0.5	16.0	4.4	1.0	80.6	1.0	*.01*
00142	0.0	1.3	5.7	0.0	0.0	17.8	*.01*
E1401	22.4	35.5	17.7	0.0	19.6	14.0	*.01*
E1403	18.1	37.3	18.9	0.0	19.3	18.9	*.01*
33512	14.6	0.0	0.0	0.0	0.0	0.0	*N.S.*
99291	0.3	6.9	1.8	4.2	13.8	27.7	*.01*
Q0043	9.5	32.7	0.0	0.0	10.8	19.2	*.01*
93320	0.4	88.8	8.1	0.0	0.0	4.8	*.01*
99253	0.5	2.6	2.2	0.0	0.0	1.1	*.01*
52601	9.0	3.2	0.0	0.0	0.0	0.0	*N.S.*
99312	0.2	4.3	0.3	0.0	3.6	3.1	*.01*
99204	0.0	8.6	0.0	0.0	4.1	0.0	*.01*
93549	0.0	0.0	198.6	0.0	0.0	0.0	*.01*
99203	0.7	10.4	0.2	0.0	3.6	1.3	*.01*
43235	0.0	0.9	1.1	0.0	1.8	0.0	*N.S.*
43239	0.0	1.6	3.7	0.0	2.2	0.0	*N.S.*
A0020	6.2	74.3	1.4	18.4	0.1	49.5	*.01*
33513	3.9	0.0	0.0	0.0	0.0	0.0	*N.S.*
99283	0.1	12.5	1.0	0.8	0.0	14.7	*.01*
90843	0.2	14.7	1.6	0.0	0.0	1.0	*.01*
27130	0.0	4.7	0.0	0.0	0.0	0.0	*N.S.*
85025	0.9	5.2	0.2	0.0	0.0	0.3	*.01*
A0150	302.5	83.2	1.9	13.0			*.01*
84443	0.6	3.4	0.3	4.4	0.0	0.0	*.01*
93880	0.0	124.9	13.6	0.0	0.0	0.0	*.01*
36415	0.2	3.2	0.9	0.2	0.0	0.1	*.01*
99205	0.3	6.9	0.7	0.0	9.3	0.0	*.01*
00562	0.0	0.0	0.0	0.0	0.0	0.0	*N.S.*
76091	0.3	54.0	0.3	0.0	0.0	0.4	*.01*
83720	1.8	11.2	0.1	2.1	0.0	0.0	*.01*
99245	0.0	2.4	0.0	0.0	0.0	12.8	*.01*

Note: Rates based on number of services denied for medical necessity per 1,000 allowed. Blank cells indicate that the code was not billed. Significance level is based on chi-square tests.

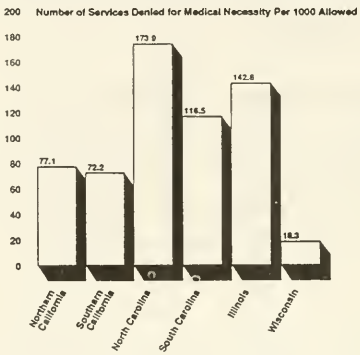
We found that for 58 of the 71 services shown in table 1, significant variations existed among carriers in the denial rates for medical necessity.

The following figures graphically illustrate this overall pattern by showing, across carriers, denial rates for three services: chiropractic (service code A2000); percutaneous transluminal coronary angioplasty, also known as PTCA (service code 92982); and critical care (service code 99291).

Looking at chiropractic services, we see that the rates of denial for medical necessity (per 1,000 services allowed) ranged from 18 to 174 among these six carriers. (See figure 1.) For PTCA, one carrier had a denial rate of 182, two had denial rates of about 30, while three carriers did not deny any services for medical necessity. (See figure 2.) Lastly, for critical care, while the overall range was smaller (0.3 to 27.7), there again was significant variation among carriers. (See figure 3.)

(Filename: C:\OPCMEDFIG2)

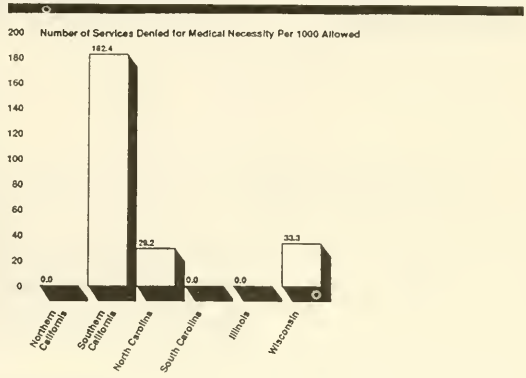
Figure 1: Variation in Denial Rates for Medical Necessity—Chiropractic Visits.



Note. Rates based on a 5 percent sample of 1992 Medicare Part B Claims.

(Filename: C:\OPCMED\FIG3)

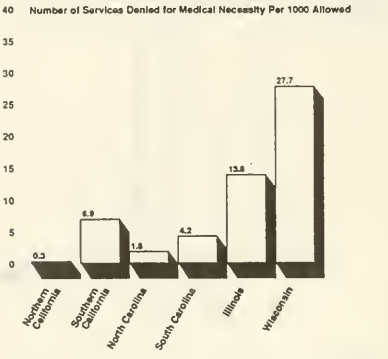
Figure 2: Variation in Denial Rates for Medical Necessity—Percutaneous Transluminal Coronary Angioplasty.



Note. Rates based on a 5 percent sample of 1992 Medicare Part B Claims.

(Filename: C.OPCMEDFIG4)

Figure 3: Variation in Denial Rates for Medical Necessity—Critical Care.



Note: Rates based on a 5 percent sample of 1992 Medicare Part B claims.

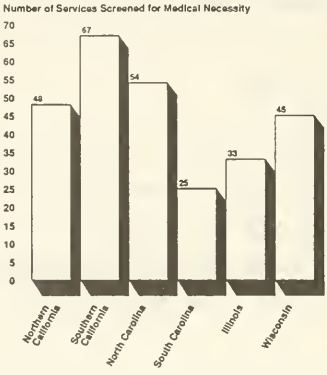
Second, we found that the number of services that carriers screened for medical necessity varied markedly. As shown in figure 4, some carriers had screens in place for almost all of the top 71 services, while others screened for little more than one third of these codes.[2]

Finally, our third finding is that the overall denial rate for medical necessity also differed among these six carriers. As shown in figure 5, at one extreme, one carrier denied as few as 1 service per 1,000 allowed, while at the other extreme, another carrier denied 23 services per 1,000 allowed.

[2]Service codes are also referred to as procedure codes.

(Filename: MEDFIG1)

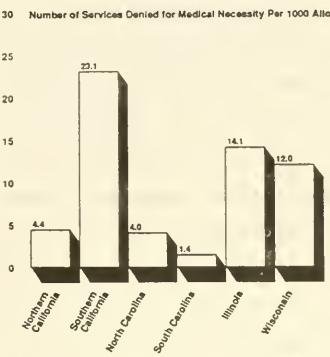
Figure 4: Number of Top 71 Services Screened for Medical Necessity by Carrier



Note: Percentages based on a 5 percent sample of Medicare Part B claims processed in 1992. Top 71 services based on allowed charges.

(Filename: C:\OPCMED\FIG5)

Figure 5: Variation in Denial Rates Among Carriers.



Note. Rates based on a 5 percent sample of 1992 Medicare Part B claims.

CONCLUSIONS

Significant variations exist among six Medicare Part B carriers in the ratio of medical necessity denials for 58 of the top 71 services. What do such differences in denial rates among carriers mean? The answer to this question depends on how these variations arise. Two plausible explanations have been advanced--with each having a different policy implication. One explanation focuses on differences in the medical policies used by carriers, while the other focuses on the billing practices of providers.

Variation Due to Differences in Medical Policy

The Social Security Act mandates that carriers pay only those Medicare Part B claims that are reasonable and medically necessary. Medicare law recognizes regional and local differences in medical practice and thus gives carriers broad latitude in defining the criteria for determining medical necessity. However, this latitude, in and of itself, produces some degree of variability in how similar claims are treated across carriers representing different geographic areas. That is, a policy cannot, at the same time, both allow for local variation in what is or is not viewed as medically necessary and also produce uniform results.

As our results show, carriers have in fact exercised this latitude. We found significant differences in both the number and types of services that are screened for medical necessity. Moreover, even when screening the same type of service, carriers used different working definitions of what is medically necessary.

For example, the first 12 visits to a chiropractor for spinal manipulation to correct a subluxation (code: A2000) must meet certain basic HCFA coverage criteria such as the following: An x ray must be available, if requested; signs and symptoms must be stated; and the precise level of subluxation must be reported. The carriers we spoke to had all incorporated these criteria into their medical policy for chiropractic spinal manipulation. HCFA requires that carriers assess the necessity of visits in excess of 12 per year, but carriers diverged in how they assessed such treatments. One carrier stated that, after 12 visits, additional documentation on medical necessity would be required. Another carrier set the number of additional visits allowed based on the injured area of the spine. When that number of additional visits was reached, this carrier required additional documentation from the provider. Still another carrier stated that, while they reviewed additional visits beyond the 12th, they usually did not require additional documentation until the 30th visit.

Given the broad variations found in denial rates across the

six carriers we examined, it would seem reasonable to conclude that some portion of that variance is due to differences in medical policies. Thus, one unintended consequence of setting medical policy locally is that, while it attempts to promote congruence between local medical policy and practice, viewed from a national perspective, it has also produced inconsistent treatment of Medicare providers and beneficiaries from one region to another, and one carrier to another.

Variations in Billing Practices

In our discussions with HCFA officials and representatives of the six carriers, it was asserted that difference in medical policy is but one possible explanation for variation in denial rates. Both the carriers and HCFA pointed to a second potential source for the observed variation in denial rates, one that focuses on differences in the billing practices of providers. Their explanation has several variants, which we summarize below:

- the various regions of the country have different levels of fraud and abuse, which in turn produce different denial rates;
- differences in denial rates could be due to aberrant billing practices by as few as two or three providers;
- in certain regions of the country, providers disregard the feedback they receive from denied claims--that is, they continue to bill for services they know are not medically necessary in the hope that some will be approved; and
- certain carriers do a better job of educating providers in how to submit Medicare claims correctly.

In sum, although at least two hypotheses can thus be advanced to explain the wide variation we found in the denial rates of our six carriers, it is important to note that (1) these findings are new: the size of this variation had not been previously examined by HCFA; and (2) HCFA is only now beginning to conduct evaluations to determine which, if either, of the above major explanations (that is, medical policy or billing practice) best accounts for the inconsistency we observed in denial rates. Given this lack of information, it has been difficult for HCFA to take a position on the question of whether a high or a low denial rate represents better public policy. HCFA officials told us that, although low denial rates are desirable from the standpoint that they imply less trouble for providers and beneficiaries, they are only desirable insofar as providers appropriately bill only for what is medically necessary. If providers are inappropriately billing Medicare, high denial rates are desirable.

The issue here, however, is not the size of denial rates, but rather their consistency. Medicare is not a local initiative. It is a national program under which beneficiaries should not receive different benefits solely because their place of residence differs. Yet we found that beneficiaries and providers have in fact been treated with considerable inconsistency by six carriers making individual determinations concerning what is and is not medically necessary. While it may

be essential for Medicare to allow for local determination of medical policy, we found that this allowance, left to itself, leads to inconsistent treatment of beneficiaries and providers.

Carrier representatives told us they believe that inter-carrier variation would be reduced if HCFA established more national medical policies that define specific parameters for what is medically necessary. What is clear from our work to date, however, is that denial rates provide useful insight into how effectively Medicare contractors are managing program dollars and serving beneficiaries and providers. We believe that HCFA needs to play a greater role in using such data to oversee carriers' claims review activities to better assure that beneficiaries and providers are equitably treated.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions that you or members of the Committee may have.

METHODOLOGY

To develop the information in this testimony, we visited six carriers and analyzed claims processed by each of them. In selecting carriers, we considered two factors: geographic location and the number of claims processed.[3] Table I.1 lists the carriers we visited and the number of claims they processed in fiscal year 1992.

[3]Our sample included two carriers from each of the following three regions: the Southeast, the Midwest, and the West. In making this selection, we sought to maximize the geographic distance between regions, while at the same time retaining the pot ntial for examining intraregional variation in medical policies. In terms of the number of claims processed, the frequency distribution of carriers is essentially bimodal--that is, there are two large clusters of carriers, those that annually process between 2 and 13 million claims and those that process between 18 and 29 million claims (2 carriers processed over 46 million claims each). Our sample included two carriers from the former cluster and four from the latter.

Table I.1: Selected Medicare Part B Carriers (Data for 1992)

Carrier	Geographic location	Number of claims processed (in millions)
California B/S	West	24
California-Occidental	West	25
Illinois B/S	Midwest	22
Wisconsin-Physician Srv.	Midwest	10
North Carolina-Conn. Gen.	Southeast	18
South Carolina B/S	Southeast	8

Taken together, these six carriers processed about 19 percent of all Part B claims in fiscal year 1992; however, because of our judgmental selection process, we cannot generalize our findings to the universe of carriers.

Source of Data

To compare medical necessity denial rates among carriers, we obtained from HCFA a 5 percent sample of 1992 Medicare Part B claims for the above six carriers. This information was abstracted from the physician/supplier portion of the Common Working File, which serves as a repository for all Medicare claims.

The Common Working File contains information on many claims-related variables, including the type of billed service and the action that was taken as a result of the claim review process. Medicare claims can contain submitted charges for more than one service; a claim for a simple medical checkup, for example, may include both the doctor's fee as well as the charge for lab tests performed during the visit. On the Medicare claim form, each billed service, or line item, appears as a separate charge with a corresponding five-digit service code that describes the type of service provided (for example, office visit, chiropractic treatment, and so on). Each of these services listed as a separate line item is subject to approval or denial by the carrier. During claims processing, carriers assign an action code to each line item that indicates that it was paid or, if denied, the reason for denial.[4]

In our analysis, we focused on two line item variables--the service and the action code. In calculating denial rates presented in our statement, we contrasted the number of services denied for lack of medical necessity with the total number of services allowed for a given service Services denied for other reasons were excluded from the analysis.

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[4]Reasons for line item denial included in the Common Working File are: benefits exhausted, non-covered care, invalid care, duplicate line item, medically unnecessary, reprocessed adjustment, secondary payer, and other.

Because there are more than 10,000 different service codes, we ranked service codes in terms of the total of allowed charges (in 1992), and then restricted our analysis to the top 71 codes.[5] Services that rank high in allowed charges are those that have high utilization rates and/or high cost per service. The top 71 service codes constitute approximately 50 percent of all Medicare Part B allowed charges.

Sampling Considerations

The 5-percent sample used in our analysis was extracted from the Common Working File by keying on the last two digits of the beneficiary identification number. This method is commonly used by HCFA, and while we have no reason to believe that it is biased, it is not, strictly speaking, a random sample, but rather an approximation of a random sample. Consequently, the tests of statistical significance presented in this testimony are included mainly for heuristic purposes: that is, to identify those codes where carriers had especially large differences in denial rates.

To avoid unstable estimates of denial activity for certain service codes with low frequencies, we focused on the top 71

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[5]The "allowed charge" is set by HCFA. The amount actually paid by HCFA is 80 percent of the allowed charge less deductible and/or co-payment.

services (based on allowed charges). This group of services generally has high utilization rates and thus sufficiently large frequencies for making inter-carrier comparisons of denial rates.

LIST OF TOP 71 PROCEDURE CODES RANKED BY ALLOWED CHARGES FOR 1992

Procedure Code/ Narrative Description
99213 Office or other outpatient visit
66984 Extracapsular cataract removal
99232 Subsequent hospital care, per day
99214 Office or other outpatient visit
99231 Subsequent hospital care, per day
99212 Office or other outpatient visit
99233 Subsequent hospital care, per day,
A0010 Ambulance service, basic life support
93307 Echocardiography, real-time with image documentation (2D)
88305 Level IV - surgical pathology, gross and microscopic examination
99223 Initial hospital care, per day
99215 Office or other outpatient visit
99254 Initial inpatient consultation for a new or established patient
66821 Discussion of secondary membranous cataract
A0220 Ambulance service, advanced life support
71020 Radiologic examination, chest, two views, frontal and lateral
90844 Individual medical psychotherapy by a physician
99222 Initial hospital care, per day
92014 Ophthalmological services: medical examination and evaluation
27447 Arthroplasty, knee, condyle and plateau
E1400 Oxygen concentrator
99238 Hospital discharge day management
93547 Combined left heart catheterization, selective coronary angiography
80019 Automated multichannel test
99244 Office consultation for a new or established patient
A2000 Manipulation of spine by chiropractor
B4150 Enteral formulae; category I
77430 Weekly radiation therapy management
B4035 Enteral feeding supply kit; pump fed, per day
99255 Initial inpatient consultation for a new or established patient,
J9217 Leuprolide acetate, for depot suspension, 7.5MG
90995 End stage renal disease (ESRD) related services, per full month
93005 Electrocardiogram, routine ECG with a least 12 leads
92982 Percutaneous transluminal coronary angioplasty
99284 Emergency department visit
99285 Emergency department visit
45385 Colonoscopy, fiberoptic, beyond splenic flexure
92012 Ophthalmological services: medical examination and evaluation
45378 Colonoscopy, fiberoptic, beyond splenic flexure
99311 Subsequent nursing facility care, per day
71010 Radiologic examination, chest
00142 Anesthesia for procedures on eye

E1401 Oxygen concentrator, manufacturer specified maximum rate greater than 2
E1403 Oxygen concentrator, manufacturer specified maximum rate greater than 4
33512 Coronary artery bypass, autogenous graft
99291 Critical care, including the diagnostic and therapeutic services
Q0043 Stationary liquid oxygen system rental, includes contents (per unit)
93320 Doppler echocardiography, pulsed wave and/or continuous wave
99253 Initial inpatient consultation for a new or established patient,
52601 Transurethral resection of prostate
99312 Subsequent nursing facility care, per day
99204 Office or other outpatient visit
93549 Combined right and left heart catheterization
99203 Office or other outpatient visit
43235 Upper gastrointestinal endoscopy including esophagus
43239 Upper gastrointestinal endoscopy including esophagus
A0020 Ambulance service, (BLS) per mile, transport, one way
33513 Coronary artery bypass, autogenous graft
99283 Emergency department visit
90843 Individual medical psychotherapy by a physician
27130 Arthroplasty, acetabular and proximal femoral
85025 Blood count
A0150 Non-emergency transportation, ambulance, base rate one way
84443 Thyroid stimulating hormone (TSH), RIA or EIA
93880 Duplex scan of extracranial arteries
36415 Routine venipuncture for collection of specimen(s)
99205 Office or other outpatient visit
00562 Anesthesia for procedures on heart, pericardium
76091 Mammography;
83720 Lipoprotein cholesterol fractionation calculation by formula
99245 Office consultation for a new or established patient

Medicare Beneficiaries Defense Fund

Statement of the

Medicare Beneficiaries Defense Fund

to the

United States House of Representatives

Committee on Small Business

and its

Subcommittee on Regulations,
Business Opportunities, and Technology

Presented by:

Katy Samiljan
Hotline Director

March 29, 1994

Thank you for the opportunity to address the Committee on Small Business' Subcommittee on Regulation, Business Opportunities and Technology. As you know, Medicare Beneficiaries Defense Fund is a national, not-for-profit organization that works to assure equal access to quality health care for seniors and people with disabilities on Medicare. MBDF identifies failings and limitations in the Medicare program, recommends systemic changes to correct them, educates the public about Medicare issues, empowers beneficiaries to help themselves and, where necessary, takes corrective action on their behalf. MBDF provides Medicare beneficiaries with direct assistance through a telephone hotline. In 1993 alone, MBDF received more than 8,000 calls concerning Medicare and related health insurance problems on our telephone hotline.

MBDF is pleased and grateful that the General Accounting Office is reporting on the wide discrepancies in practices and procedures among the 34 private insurance carriers responsible for processing Medicare Part B claims under contract with the Health Care Financing Administration. The GAO's findings support MBDF's lifetime experience with the Medicare program. Medicare carriers are denying coverage to Medicare patients in an arbitrary and irrational manner.

These arbitrary denials are especially troubling because they affect seniors and people with disabilities in poor health and living on small fixed incomes -- often near or at the poverty level. Medicare carrier practices have left all too many ill and frightened patients without care, without coverage and without recourse.

Arbitrary claim denials is the single most intractable problem facing seniors and people with disabilities on Medicare. With no rational explanation, the same Medicare carrier will sometimes provide coverage and other times deny coverage to the same patient for the same service performed by the same provider. Or, one Medicare carrier will cover some beneficiaries and deny coverage to others for the same service. Or, one Medicare carrier will deny coverage but a different carrier will provide coverage for the same service. This problem affects at least 15% of MBDF's clients. We have no doubt that Medicare carriers throughout the country arbitrarily and improperly deny claims for several hundred thousand Medicare beneficiaries each year.

There is no good reason for the wide disparity in Medicare claims handling throughout the country. Medicare is a national program and is required to provide coverage for most reasonable and necessary health care services to all its enrollees nationwide. Despite this basic legal requirement, the Health Care Financing Administration freely permits the 34 Part B carriers to establish and apply their own unique and idiosyncratic "utilization screens" for a wide array of procedures, rather than setting national screens for these procedures.

Utilization screens are computer-driven tests concerning 1) the circumstances under which a service should be covered and 2) the appropriate number of times a service should be rendered before it is no longer medically necessary. Utilization screens direct the carriers' computers to automatically suspend claims for payment that fall outside reasonable usage parameters; since medical necessity turns on the specific conditions of a patient and not on rules of thumb, these parameters may or may not bear any relationship to whether a particular service is "reasonable and necessary" under Medicare. As a result of these screens, Medicare patients in different parts of the nation receive different treatment and do not receive coverage for a variety of reasonable and necessary services.

Unlike many Medicare issues, however, this problem is entirely and easily solvable. HCFA has the authority and the ability to establish its own national screens for all services in which medical necessity is in question. If HCFA removes this authority from the carriers and assumes for itself the responsibility of establishing national screens, beneficiaries will receive more uniform and proper coverage under Medicare.

Background:

Allow me to offer a brief sketch of the Medicare program and to explain why local carriers maintain such wide discretion over Medicare coverage and reimbursement issues.

When Congress enacted the Medicare laws, it rightly directed the government to cover all reasonable and necessary procedures not explicitly excluded from coverage. The Health Care Financing Administration, in turn, established regulations for administering the program and some limited coverage policy. In order to respond effectively to local customs and practice, however, HCFA has given the local carriers who process the Medicare claims enormous discretion with regard to coverage and reimbursement policy.

Under this program, the Part B carriers have the freedom to set the content and application of coverage parameters -- the terms for coverage --for most procedures. They may limit the number of times a beneficiary can receive coverage for a particular service. They may program their computers to screen out claims that exceed their coverage parameters and deny those claims on medical necessity grounds. Moreover, HCFA does not require the carriers to alert providers to their coverage parameters. HCFA appears to believe that disclosure of utilization screens would destroy their utility. If disclosed, providers would present their claims to fall within acceptable utilization parameters.

If a provider submits additional medical documentation demonstrating medical need, these claims generally will be covered on appeal. If not, the patient is generally liable.

I will proceed to explain the pernicious effect carrier coverage discrepancies have on Medicare patients, why these coverage discrepancies occur, how to correct them -- in part -- and finally, how a universal Medicare program might work in this country.

Beneficiaries are Victims

Beneficiaries are ultimately the victims of erroneous carrier coverage and reimbursement decisions. Scores of our clients have endured threats from collection agencies seeking payment for services the Medicare carrier should have reimbursed; other clients have reported difficulty obtaining further treatment from their doctors because of Medicare carriers' delays or mistakes in payment. Many patients end up paying for their care privately or foregoing care altogether because they cannot afford its cost. Tragically, most beneficiaries wrongly believe that Medicare simply does not cover their services.

Consider these examples: One of our clients, whom I will call Mr. J, received an ultrasonic exam of the prostate because his physicians suspected prostate cancer. Pennsylvania Blue Cross Blue Shield, the carrier for his area, denied payment. The Explanation of Medicare Benefits form Mr. J received simply states, "The information we have in your case does not support the need for this service." When Medicare did not pay, the doctor sent Mr. J's bill to a collection agency.

Another client, Mr. T, was forced to pay $1050 up-front to his doctor for an MRI. Empire Blue Cross Blue Shield reimbursed him $202.80 for a CAT scan. The Explanation of Medicare Benefits form does not even indicate that the carrier rejected the MRI claim and paid it as a CAT scan. Mr. T has spent the last year fighting Medicare for higher reimbursement.

Yet another client, Mr. G, received neurologic services for a problem following surgery. The Medicare carrier denied coverage for all his neurologic services totalling $1634, stating that "Medicare does not pay for these charges because the cost of the care before and after surgery is part of the approved amount for the surgery." In this case, however, the neurologic care was completely unrelated to the surgical care and should have been covered separately. Mr. G has been challenging Medicare's denial for more than two years. He is severely ill and probably will not live long enough to collect his due Medicare benefits.

The range of services for which MBDF's clients receive coverage denials is enormous. In the last several months, MBDF

has seen wrongful denials for anesthesiologists who are standing-by in case of emergency, injections in conjunction with CAT scans of the pancreas, biannual pap smears for people with histories of cervical cancer, physical therapy services, MRIs and chiropractic visits. Our clients alone are denied hundreds of thousands of dollars in Medicare benefits that they cannot afford to lose. These denials devastate our clients financially and emotionally.

These arbitrary denials also unfairly affect delivery of medical services and jeopardize the health care of many beneficiaries who live on small, fixed incomes. Providers who understand both how utilization screens work and the flexibility of the Medicare program can ensure that their patients receive care and coverage for their care. But there are other providers who do not understand carrier practices or who do not want to bear the burden of challenging Medicare. If they suspect that Medicare carrier screens will result in a denial of coverage, they may not be willing to deliver services unless their patients sign agreements to pay privately for them. Through these agreements, doctors can shift the burden of securing Medicare coverage to their patients and can protect themselves financially.

Unfortunately, many patients who sign these agreements do not have the knowledge or wherewithal to pursue Medicare coverage. Those who do challenge the system must devote extraordinary amounts of time and emotional energy to the process. Moreover, patients who want to appeal require medical justification from their doctors. However, they may have difficulty obtaining this justification from doctors who have secured agreements from them to pay privately.

MBDF will help the hundreds of people calling our office to obtain necessary care and coverage by appealing and demonstrating medical necessity -- so long as the callers' doctors are willing to cooperate. But we and the handful of other advocacy organizations nationwide who understand the Medicare program do not begin to reach the hundreds of thousands of people needing assistance.

Medicare Reversal Rates

As you know, HCFA's own statistics show that only 2% of all claims are appealed for initial review but that almost two out of every three of these appeals results in additional coverage. Moreover, fewer than 2% of all claims are appealed for second and third level review and, again, at each of these levels there is a 60% chance of reversal resulting in additional benefits. Medicare's reversal rates show that the program is currently shortchanging the people who appeal hundreds of millions of dollars. If more patients appealed, we would see that carriers erroneously deny even more staggering sums to Medicare patients.

Although most beneficiaries do not challenge their Medicare denials, if they appealed, MBDF is confident that they would have as a high a chance of securing coverage for their care as those who currently do appeal. Indeed, we generally counsel our clients to appeal whenever they receive a Medicare denial, without knowing much about their case. We find that, with proper documentation illustrating medical necessity, we can virtually always secure coverage for our clients on appeal.

The disturbingly high reversal rates are hardly surprising given the cavalier manner in which carriers apply utilization screens to deny claims. Congress should view the reversal data as evidence that carriers are acting rashly to deny coverage and that HCFA has not acted to ensure that carrier administration of Medicare claims comports with law. Congress must recognize that most seniors and people with disabilities on Medicare do not understand their coverage rights or their right to challenge Medicare denials; even their friends and relatives who may be healthier and stronger find the Medicare program virtually impenetrable. Most people believe fighting the bureaucracy is futile and resign themselves instead to despair and frustration.

Explanations For These Medicare Carrier Denials

There are three deeply troubling explanations for these arbitrary Medicare denials and the substantial variations among Part B carriers in the ratio of approvals to denials of the same services. First, HCFA allows carrier medical staff too much discretion in establishing parameters for coverage; second, carrier claims processing staff generally do not have the skills, the time or the necessary medical documentation to make appropriate medical necessity determinations; and third, the Health Care Financing Administration, whose job it is to oversee the carriers in their administration of claims, fails to assure that carriers set appropriate policy and pay claims in compliance with law.

First, carrier medical staff have enormous discretion in establishing Medicare coverage policies. They set medical necessity standards for many procedures -- determining which diagnoses are required for coverage, establishing utilization screens; making coverage and pricing decisions for "new" procedures; and ruling on which procedures are "experimental" and therefore not covered.

Carrier medical staff do not adhere to any national standards for many medical coverage policies, nor must they answer to anyone at HCFA for their coverage policies. They are simply expected to follow a formalized protocol to fashion coverage policies that conform with local practice standards. Their virtual unilateral control over medical policies ultimately

results in the wide coverage discrepancies so injurious to Medicare patients.

Second, carrier claims processing staff are required to implement medical policy by relying on computer edits which screen out claims requiring review for medical necessity. The computer indicates that the patient has exceeded a utilization threshold -- in other words, this service is not necessary for the "average" patient -- or that the service is not necessarily justified for the diagnosis. And, simply because the claim has been flagged for medical review, carrier claims processing staff may deny the claim.

Carrier staff generally lack the formal medical training and the time to make a fair determination of the medical necessity of a service. They often have only high school degrees and they are responsible for processing hundreds of claims a day. Even if they had the skills and time, they do not typically have any medical documentation to review and no basis other than the carrier's medical policy to deny the claim.

Third, to the extent carrier coverage policies are unreasonable or unjustified, HCFA does not regulate them. HCFA appears to make no effort to ensure that carrier utilization screens work fairly and efficiently to deny claims on medical necessity grounds. To our knowledge, HCFA takes a hands-off approach to the content and application of carrier utilization screens. Moreover, HCFA has not provided needed funding for carriers to hire and train claims processing staff who can appropriately review claims for medical necessity.

Addressing Discrepancies in Carrier Coverage Determinations

One way to address the problem of widely varying carrier determinations is for HCFA to set most, if not all, utilization screens. There is no compelling reason why screens to detect overutilization of services should be different in different parts of the country. Moreover, nationally set utilization screens should not affect local customs. Local customs and practices should be largely irrelevant when determining whether a service is reasonable and necessary and therefore covered. Carriers should only be able to establish their own utilization screens in exceptional circumstances for a temporary period, where they detect patterns of abuse that HCFA has not yet addressed through screens.

Second, to the extent that carriers do establish utilization screens, HCFA should set strict guidelines for their content, including: strong objective evidence that providers in the locality are exceeding reasonable norms in their delivery of a particular service; medical evidence that the screens established are in keeping with reasonable norms; and substantial additional

justification for establishing a screen that is not in keeping with screens established by other carriers. In short, carriers should be required to answer for the screens they establish and not be able to hide behind them as they currently do.

HCFA also should regulate and control carrier application of these utilization screens so that they are used effectively and do not foster arbitrary and irrational denials. To this end, HCFA must ensure that carrier claims processing staff have the time and necessary skills to review claims for medical necessity.

Third, when utilization thresholds are exceeded and claims denied, the Explanation of Medicare Benefits form should inform beneficiaries that additional medical justification is needed to secure coverage.

Fourth, utilization parameters should be public information. If public, some providers would adjust their practices to conform with these screens, where appropriate, and would know to provide additional medical documentation where services fell outside parameters. HCFA believes that this information would undermine the efficacy of the screens. To the contrary, it would protect beneficiaries from erroneous denials and unnecessary services.

Fifth, providers should not have the right to ask patients to pay privately for a service they believe is medically reasonable and necessary. Unless the patient is asking them to perform the service and they do not believe it is medically necessary, providers should be required to deliver the service and provide the medical justification for it. And if Medicare ultimately deems the service medically unnecessary, the providers should have to bear the cost, not the beneficiaries.

Coverage Inconsistencies in Private Insurance Plans

MBDF recognizes that there are inconsistencies in coverage and reimbursement decisions in private health insurance plans and that inconsistencies are to some extent inevitable. People are making subjective decisions about what services are reasonable and necessary and what they are worth. The process is not entirely objective.

These inconsistencies are particularly prevalent and can be most serious in managed care plans. Different primary care physicians -- with different training, skills, practice attitudes and objectives -- have substantial discretion to decide, among other things, whether specialist services are warranted, whether emergency services are truly emergency services and the appropriate length of a hospital inpatient stay.

The best consumers can hope for is widely available public information about the coverage practices of various insurers.

With this information, consumers can make informed choices about their medical care and will better understand their rights to coverage. Insurers, in turn, will likely act more responsibly in formulating coverage policy.

Consumers also need an efficient and workable appeal mechanism. Medicare provides beneficiaries and providers with an avenue for challenging its denials in both the traditional fee-for-service and managed care settings, albeit a somewhat cumbersome one. Federal insurance legislation and even the President's bill, however, do not afford individuals the grievance and appeal protections Medicare provides. As a result, to the extent private insurers, including managed care plans, wrongly deny care on medical necessity grounds and patients do not have adequate appeal protections, these insurers leave millions of people in this country who live on small fixed incomes without necessary care or appropriate coverage and without any effective avenues to secure this care or coverage.

"Medicare for All"

"Medicare for All" has the potential to be a wise health reform strategy. However, critical problems with the Medicare program must first be corrected.

1. First and foremost, Medicare must cover preventive services, prescription drugs and long-term care.

2. Beneficiaries should be removed from the reimbursement process. Beneficiaries who are strong and healthy can do little to secure payment for claims that exceed utilization thresholds and medical necessity denials without the provider's assistance. Beneficiaries who are ill and unable to handle denials generally are forced to forego much-needed coverage. MBDF understands that HCFA is working to remove beneficiaries from the reimbursement process and to make Medicare an efficient system for them; we applaud its efforts to do so.

3. Ideally, HCFA should eliminate screens as a method for denying individual claims without a review of all necessary medical documentation. Screens should be used only to identify and regulate the practices of providers who appear to be providing excessive services. These providers should pay the price of delivering unnecessary services -- not their patients who have little control over the services they receive.

4. If we must use screens to identify claims which fall outside utilization "norms" for medical necessity review, HCFA should develop most, if not all, of these

screens based on discussions with the carriers as to which services warrant screens. HCFA should base its development of screens on objective evidence of lack of medical necessity and input from medical professionals. This will ensure that carriers do not have complete and unfettered discretion to determine medical necessity and apply screens for any procedures they choose. To the extent their screens do not flag unnecessary procedures efficiently, they unjustly burden beneficiaries and providers to provide medical justification to secure coverage. Carriers may need to exercise their own discretion on some local practices and new and emerging services. However, this discretion should be a temporary measure until HCFA can make its own findings. As a general principle, similar claims should receive similar treatment across carriers. There is no justification for compelling a beneficiary to live in one state rather than another in order to secure Medicare coverage for a particular condition.

5. For claims that exceed utilization thresholds, carriers with appropriate skills and adequate time should be expected to request and review additional medical documentation, if necessary, before denying payment. If they still deny the claim, the Explanation of Medicare Benefits form should note that Medicare deemed the claim medically unreasonable and unnecessary but that, with appropriate medical documentation, it might be paid on appeal.

6. As an incentive to process claims properly, carriers should be required to pay interest on claims they erroneously deny.

7. Medicare carrier staff who assist beneficiaries must have a solid mastery of the Medicare program or the ability to find out answers quickly and accurately.

8. Consumer information and education must improve in content and increase in volume before beneficiaries can truly understand their rights. MBDF applauds the Congressional appropriation of $10 million for health insurance counseling services both this year and last. The $40,000 contract we hold through the New York State Office for the Aging helps us serve more than 800 callers a month. Unfortunately, $10 million a year is not nearly enough to serve all the beneficiaries requiring assistance.

The best health care system we can offer our citizens is one that provides necessary care and coverage for that care in a fair and equitable manner. Congress must work from this premise as it scrutinizes the Medicare program and contemplates the future of health care in this country. Seniors and people with disabilities on Medicare suffer considerably from arbitrary claim denials. As a group, they are shortchanged millions of dollars. Individually, they are suffering physically, suffering financially, suffering emotionally and foregoing necessary treatment.

As the number of people on Medicare grows and Congress considers a "Medicare For All" plan, the need for sound reform becomes more desperate. Medicare must expand to cover long-term care, prescription drugs and preventive services. Medicare Beneficiaries Defense Fund strongly believes that, with reform, Medicare can provide uniform and even-handed coverage for everyone in this nation.

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